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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055525	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Crenshaw Nursing Home	1900 S Longwood Ave Los Angeles, CA 90016

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 - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44294 Based on observation, interview and record review, the facility failed to protect one of three sampled residents (Resident 1), from physical abuse (willful infliction of injury with resulting physical harm, pain, or mental anguish) by Resident 2, by failing to: 1. Ensure Resident 1 (victim) was not subjected to a repetitive physical abuse from Resident 2 (aggressor). 2. Ensure Resident 1 and Resident 2 were separated and were not left to continue residing in the same room, after Resident 1 reported to a Licensed Vocational Nurse (LVN 1) that Resident 2 hit him on 4/1/ 2024. 3. Ensure Resident 1 and Resident 2 were separated, after Resident 2 hit Resident 1 on the right eye on 4/23/2024, causing Resident 1 to sustain a red bruise (an injury appearing as an area of discolored skin on the body, caused by a blow or impact) and swelling around the right eyelid. 4. Develop a care plan for Resident 1 and 2, with interventions to prevent further abuse on 4/1/2024 and 4/23/2024, after Resident 1 alleged to have been hit by Resident 2. 5. Follow their policy and procedure (P&P) Abuse & Mistreatment of Residents, which indicated when incidents involved the health, welfare, or safety of residents were reported, the involved resident(s) should be removed from the environment that threatened resident's health, welfare, or safety. As a result, Resident 2 hit Resident 1, and Resident 1 sustained a swelling and red discoloration to the right eyelid on 4/23/2024.This deficient practice also placed Resident 1 and other residents at risk for further abuse, that could result in serious physical harm/ injuries, hospitalization , and death. On 4/24/2024 at 2:30 p.m., an Immediate Jeopardy ([IJ] a situation in which the facility's noncompliance with one or more requirements of participation has cause, or is likely to cause serious injury, harm, impairment, or death to a resident) was called in the presence of Director of Nursing (DON) and Administrator (ADM) due to the facility ' s failure to protect Resident 1 from physical abuse by Resident 2 on 4/1/2024 and 4/23/2024, that resulted to swelling and red bruise (when a part of the body is injured and small blood vessels leak out) on the right eyelid. (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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NAME OF PROVIDER OR SUPPLIER Crenshaw Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 1900 S Longwood Ave Los Angeles, CA 90016	

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 4/26/2024 at 11:01 a.m., the facility submitted an acceptable IJ removal plan ([IJRP] interventions to immediately correct the deficient practices). After verification of IJRP ' s implementation through observation, interview, and record review, the IJ was removed while onsite on 4/26/24 at 12:18 p.m., in the presence of the DON, ADM, Nurse Consultants 1 and 2. The IJRP included the following immediate actions: 1. On 4/23/2024, the facility moved Resident 1 from room B to C. 2. On 4/24/2024, the psychiatrist (a physician specializes in mental illness) conducted a bedside evaluation for Resident 1 and Resident 2. 3. On 4/23/24, the DON updated the care plan for Residents 1 and 2 and addressed the allegations of abuse. 4. On 4/24/2024, LVN 1 was placed on suspension pending investigation. 5. On 4/24/2024, the DON informed Resident 2 ' s physician of the alleged abuse, the physician ordered Resident 2 to be transferred to the general acute care hospital (GACH) for further evaluation, but Resident 2 refused. The physician was made aware and instructed the facility to continue to monitor Resident 2. 6. On 4/24/2024, the DON informed Resident 1 ' s physician of alleged abuse. The physician ordered Resident 1 to be transferred to GACH for further evaluation. 7. On 4/24/24, The DON notified the California Department of Public Health (CDPH), local police department, and Ombudsman (patient advocate) regarding two alleged physical abuse incidents that occurred on 4/1/24 and 4/23/24. 8. On 4/24/24, the ADM and the DON initiated investigations for the two allegations that occurred on 4/1/24 and 4/23/24. 9. On 4/24/2024, the ADM/DON/QA Consultant conducted in-services for all staff regarding the facility ' s abuse prevention policy. The staff were trained on securing the resident (victim) by removing and/or separating the resident from the alleged perpetrator, conduct assessments on resident(s) who were involved in the allegation, investigate the incident and report to mandated agencies. Findings: a). A review of Resident 1 ' s Admission record, dated 4/23/2024, indicated Resident 1 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnosis of essential primary hypertension (high blood pressure) type 2 diabetes mellitus (abnormal blood sugar) and muscle weakness. A review of Resident 1 ' s Minimum Data Set ([MDS], a standardized assessment and care screening tool), dated 1/5/2024, indicated Resident 1 had an intact cognition (mental capacity), required supervision (oversight help) with toileting and showers and was independent with personal hygiene and mobility (resident completes the activity with no assistance). (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of Resident 1 ' s History and Physical (H&P), dated 1/30/2024 indicated Resident 1 had the capacity to understand and make decisions. A review of Resident 1 ' s care plan, titled Abuse, dated 4/1/2023, indicated Resident 1 will be free from abuse. One of the interventions indicated, I am aware of the facility policy for reporting abuse and completing the concern form. b). A review of Resident 2 ' s Admission record, dated 4/23/2024, indicated Resident 2 was admitted to the facility on [DATE], with diagnoses of schizophrenia (a chronic and severe mental disorder that affects how a person thinks, feels, and behaves) with striking out behavior, hypertensive heart disease (high blood pressure that affects the heart). A review of Resident 2 ' s MDS, dated [DATE], indicated Resident 2 had intact cognition and was independent with mobility. The MDS indicated Resident 2 had schizophrenia and was on antipsychotic medication (medication to manage schizophrenia). A review of Resident 2 ' s H&P, dated 7/21/2023 indicated Resident 1 had the capacity to understand and make decisions. A review of Resident 2 ' s care plan, titled Episodes of striking out, dated 1/12/2024, indicated staff will monitor and record episodes of striking out behavior. A review of Resident 2 ' s physician ' s order dated 9/13/2023, indicated quetiapine fumarate (medication for mental disorders) 50 milligrams ([mg] unit of measurement) at bedtime for schizophrenia manifested by episodes of striking out. A review of LVN 1 ' s progress notes dated 4/1/2024 at 0152 (1:52 a.m.), indicated the LVN 1 responded to a loud, slammed door at Resident 2 ' s room. The progress notes indicated when LVN 1 asked Resident 2 what happened, Resident 2 stated he slammed the door because the M F kept opening the door (referring to Resident 1). The notes indicated Resident 2 shouted at LVN 1 to close the door. During a concurrent observation and interview on 4/23/2023 at 8:17 a.m. with Certified Nurse Assistant (CNA) 1, Resident 1 and Resident 2 were observed in the same room. CNA 1 confirmed Resident 1 and Resident 2 were still in the same room (Room B). During a concurrent observation and interview on 4/23/2024 at 8:17 a.m., Resident 1 and Resident 2 were in the same room (Room B). Resident 1 stated Resident 2 hit him on the face on 4/1/2024, and on 4/23/2024 early morning. Resident 1 was observed with a red bruise and a swollen right eye lid. Resident 1 stated Resident 2 hit him on the face (pointing to both eyes and bridge of the nose). Resident 1 stated he told the licensed nurses, and CNA that Resident 2 kept hitting him. Resident 1 stated Resident 2 used to close the door so no one would see him hitting Resident 1. Resident 1 stated the facility did not offer him a room change and he did not feel safe with sharing a room with Resident 2. During an interview with Resident 2 on 4/23/2024 at 8:46 a.m., Resident 2 stated he did not like Resident 1 leaving the door open. Resident 2 stated he preferred the door closed so he could sleep better, and for privacy. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview with CNA 1 on 4/23/2024 at 8:46 a.m., CNA 1 stated Resident 1 complained Resident 2 hit him on the right eye on 4/23/2024 at approximately 1:30 a.m. CNA 1 stated he immediately informed LVN 1 and LVN 1 assessed Resident 1. CNA 1 stated the concerns about Resident 2 hitting Resident 1 had been reported to the DON and ADM. CNA 1 stated he did not know if anything had been done for Resident 1. During a phone interview with former Housekeeping Supervisor (HKS) on 4/23/2024 at 9:12 a.m., the HKS stated, on 4/1/2024, he observed Resident 2 and Resident 1 in their room, and Resident 2 hit Resident 1. The HKS did not remember the part of Resident 1 ' s body Resident 2 hit. The HKS stated a CNA and LVN (unable to recall names) went into the room to check the residents but left both residents in the same room. The HKS stated he did not know the facility ' s protocol regarding resident-to-resident abuse incidents. During a phone interview with the facility ' s Secretary on 4/23/2024 at 10:58 a.m., the Secretary stated he translated (Spanish to English) for LVN 1, when LVN 1 was interviewing Resident 1 on 4/1/2024, regarding the alleged abuse incident. The Secretary stated Resident 1 reported that Resident 2 wanted the door to their room (Resident 1 and 2) closed but Resident 1 wanted the door open (date and time unknown). The Secretary stated, on 4/23/2024 at approximately 1:30 a.m., she also translated for LVN 1, regarding a second abuse incident involving Residents 1 and 2. The Secretary stated Resident 1 reported that Resident 2 hit him on his face and rib cage. The Secretary stated LVN 1 notified the ADM and DON of both incidents but did not move the residents to separate rooms. During a concurrent interview and record review with the DON on 4/23/2024 at 11:12 a.m., Resident 2 ' s Medication Administration Records (MAR) for March and April 2024, were reviewed. The DON stated the MAR indicated a total of six (6) episodes of striking out behavior from 3/31/2024 to 4/2/2024. The DON stated staff ' s interventions for Resident 2 ' s striking out behavior included monitoring the resident for 72 hours after each incident, deescalating the situation, distracting the resident, and having one staff monitor the resident closely. The DON stated staff did not intervene on 4/1/2024, when or after Resident 2 hit Resident 1. During a concurrent observation and interview with the DON on 4/23/2024 at 11:20 a.m., in the residents ' room, Resident 1 was observed sitting at the edge of his bed. The DON stated Resident 1 ' s right eyelid was swollen `with a red bruise. The DON stated Resident 1 pointed at the bridge of his nose and partially to both eyes when asked where Resident 2 had hit him. The DON stated he did not think Resident 1 was hit on the right eyelid. The DON stated both residents should have been separated after the first alleged abuse incident dated 4/1/2024, to prevent further abuse. The DON stated he did not investigate the abuse incident on 4/1/2024, because he did not know about it. The DON also stated on 4/23/2024, LVN 1 texted the DON to report that Resident 2 hit Resident 1. The DON stated the residents were left in the same room because Resident 1 was asleep. During a phone interview with LVN 1 on 4/23/2024 at 12:07 p.m., LVN 1 stated CNA 1 reported to her (LVN 1) that Resident 1 alleged Resident 2 hit him on the face, on 4/23/2024 around 1:30 a.m. LVN 1 stated she left both residents in the same room, did not document the incident in the residents ' progress notes, or change of condition (COC) form. LVN 1 stated she did not create a care plan with interventions to prevent further abuse and did not start a 72-hour monitoring for both residents. LVN 1 stated she should have moved Resident 1 to another room, for safety and prevent further abuse. LVN 1 stated if the residents were moved to separate rooms after the first incident on 4/12024, Resident 2 could not have hit Resident 1 for the second time on 4/23/2024. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of the facility ' s undated P&P titled, Abuse & Mistreatment of Residents, indicated when incidents involved the health, welfare, or safety of residents were reported, the involved resident(s) should be removed from the environment that threatened the resident ' s health, welfare, or safety. The P&P indicated the charge nurse and/or nursing supervisor should conduct an immediate resident assessment to identify any injuries or extent of injuries, if any, notify the attending physician of incident for necessary interventions. The P&P indicated the charge nurse and/or nursing supervisor shall initiate resident care plan to reflect current conditions and measures taken to prevent recurrence of event, document findings and if the suspected perpetrator was another resident, the resident shall be separated to avoid further contact.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44294 Based on interview and record review, for two of two sampled residents (Resident 1 and Resident 2), the facility failed to implement its policy and procedure titled, Abuse & Mistreatment of Residents, which indicated the following: 1. When incidents involving the health, welfare, or safety of residents are reported, the involved resident(s) shall be removed from the environment that threatened resident's health, welfare, or safety. 2. The Charge Nurse and/or nursing supervisor shall conduct an immediate resident assessment to identify any injuries or extent of injuries, if any, shall notify the attending physician of incident for necessary interventions and notify family members and or legal agents of incident. 3. The Charge Nurse and/or Nursing Supervisor shall initiate resident care plan to reflect current conditions and measures taken to prevent recurrence of event. All findings are to be documented and if the suspected perpetrator is another resident, the residents shall be separated to avoid any further contact. As a result, Resident 1 was hit by Resident 2, and Resident 1 sustained a swelling and red discoloration to the right eyelid. This deficient practice also placed Resident 1 and other residents at risk for further abuse, that could result in serious physical harm/ injuries, hospitalization , and death. Findings: a). A review of Resident 1 ' s Admission record, dated 4/23/2024, indicated Resident 1 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnosis of essential primary hypertension (high blood pressure) type 2 diabetes mellitus (abnormal blood sugar) and muscle weakness. A review of Resident 1 ' s Minimum Data Set ([MDS], a standardized assessment and care screening tool), dated 1/5/2024, indicated Resident 1 had an intact cognition, required supervision (oversight help) with toileting and showers and was independent with personal hygiene and mobility (resident completes the activity with no assistance). A review of Resident 1 ' s History and Physical (H&P), dated 1/30/2024 indicated Resident 1 had the capacity to understand and make decisions. A review of Resident 1 ' s care plan, titled Abuse, dated 4/1/2023, indicated Resident 1 will be free from abuse. One of the interventions indicated, I am aware of the facility policy for reporting abuse and completing the concern form. b). A review of Resident 2 ' s Admission record, dated 4/23/2024, indicated Resident 2 was admitted to the facility on [DATE], with diagnosis including schizophrenia, hypertensive heart disease (high blood pressure that affects the heart). (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 2 ' s MDS, dated [DATE], indicated Resident 2 had intact cognition and was independent with mobility. The MDS indicated Resident 2 had schizophrenia and was on antipsychotic medication (medication to manage schizophrenia). A review of Resident 2 ' s H&P, dated 7/21/2023, indicated Resident 1 had the capacity to understand and make decisions. A review of Resident 2 ' s care plan, titled Episodes of striking out, dated 1/12/2024, indicated staff will monitor and record episodes of striking out behavior. A review of Resident 2 ' s physician ' s order dated 9/13/2023, indicated quetiapine fumarate (medication for mental disorders) 50 milligrams ([mg] unit of measurement) at bedtime for schizophrenia manifested by episodes of striking out. A review of LVN 1 ' s progress notes dated 4/1/2024 at 0152 (1:52 a.m.), indicated the LVN 1 responded to a loud, slammed door at Resident 2 ' s room. The progress notes indicated when LVN 1 asked Resident 2 what happened, Resident 2 stated he slammed the door because the M F kept opening the door (referring to Resident 1). The notes indicated Resident 2 shouted at LVN 1 to close the door. During a concurrent observation and interview on 4/23/2023 at 8:17 a.m. with CNA 1, CNA 1 stated Resident 1 and Resident 2 were in the same room (Room B), because they were roommates. During a concurrent observation and interview on 4/23/2024 at 8:17 a.m., Resident 1 and Resident 2 were in the same room (Room B). Resident 1 stated Resident 2 hit him on the face on 4/1/2024, and on 4/23/2024 early morning. Resident 1 was observed with a red bruise and a swollen right eye lid. Resident 1 stated Resident 2 hit him on the face (pointing to both eyes and bridge of the nose). Resident 1 stated he told the licensed nurses, and Certified Nurse Assistant (CNA) that Resident 2 kept hitting him. Resident 1 stated Resident 2 used to close the door so no one would see him hitting Resident 1. Resident 1 stated the facility did not offer him a room change and he did not feel safe with sharing a room with Resident 2. During an interview with Resident 2 on 4/23/2024 at 8:46 a.m., Resident 2 stated he did not like Resident 1 leaving the door open. Resident 2 stated he preferred the door closed so he could sleep better, and for privacy. During an interview with CNA 1 on 4/23/2024 at 8:46 a.m., CNA 1 stated Resident 1 complained Resident 2 hit him on the right eye on 4/23/2024 at approximately 1:30 a.m. CNA 1 stated he immediately informed LVN 1 and LVN 1 assessed Resident 1. CNA 1 stated the concerns about Resident 2 hitting Resident 1 had been reported to the DON and ADM. CNA 1 stated he did not know if anything had been done for Resident 1. During a phone interview with former Housekeeping Supervisor (HKS) on 4/23/2024 at 9:12 a.m., the HKS stated, on 4/1/2024, he observed Resident 2 and Resident 1 in their room, and Resident 2 hit Resident 1. The HKS did not remember the part of Resident 1 ' s body Resident 2 hit. The HKS stated a CNA and LVN (unable to recall names) went into the room to check the residents but left both residents in the same room. The HKS stated he did not know the facility ' s protocol regarding resident-to-resident abuse incidents. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review with the DON on 4/23/2024 at 11:12 a.m., Resident 2 ' s Medication Administration Records (MAR) for March and April 2024, were reviewed. The DON stated the MAR indicated a total of six (6) episodes of striking out behavior from 3/31/2024 to 4/2/2024. The DON stated staff ' s interventions for Resident 2 ' s striking out behavior included monitoring the resident for 72 hours after each incident, deescalating the situation, distracting the resident, and having one staff monitor the resident closely. The DON stated staff did not intervene on 4/1/2024, when or after Resident 2 hit Resident 1. During a phone interview with the facility ' s Secretary on 4/23/2024 at 10:58 a.m., the Secretary stated he translated (Spanish to English) for LVN 1, when LVN 1 was interviewing Resident 1 on 4/1/2024, regarding the alleged abuse incident. The Secretary stated Resident 1 reported that Resident 2 wanted the door to their room (Resident 1 and 2) closed but Resident 1 wanted the door open (date and time unknown). The Secretary stated, on 4/23/2024 at approximately 1:30 a.m., she also translated for LVN 1, regarding a second abuse incident involving Residents 1 and 2. The Secretary stated Resident 1 reported that Resident 2 hit him on his face and rib cage. The Secretary stated LVN 1 notified the ADM and DON of both incidents but did not move the residents to separate rooms. During a phone interview with LVN 1 on 4/23/2024 at 12:07 p.m., LVN 1 stated CNA 1 reported to her (LVN 1) that Resident 1 alleged Resident 2 hit him on the face, on 4/23/2024 around 1:30 a.m. LVN 1 stated she left both residents in the same room, did not document the incident in the residents ' progress notes, or change of condition (COC) form and did not notify the physician and family member. LVN 1 stated she did not create a care plan with interventions to prevent further abuse and did not start a 72-hour monitoring for both residents. LVN 1 stated she should have moved Resident 1 to another room, for safety and prevent further abuse. LVN 1 stated if the residents were moved to separate rooms after the first incident on 4/12024, Resident 2 could not have hit Resident 1 for the second time on 4/23/2024. During a concurrent observation and interview with the DON on 4/23/2024 at 11:20 a.m., in the residents ' room, Resident 1 was observed sitting at the edge of his bed. The DON stated Resident 1 ' s right eyelid was swollen `with a red bruise. The DON stated Resident 1 pointed at the bridge of his nose and partially to both eyes when asked where Resident 2 had hit him. The DON stated he did not think Resident 1 was hit on the right eyelid. The DON stated both residents should have been separated after the first alleged abuse incident dated 4/12024, to prevent further abuse. The DON stated he did not investigate the abuse incident on 4/1/2024, because he did not know about it. The DON also stated on 4/23/2024, LVN 1 texted the DON to report that Resident 2 hit Resident 1. The DON stated the residents were left in the same room because Resident 1 was asleep. A review of the facility's undated P&P titled, Abuse & Mistreatment of Residents, indicated when incidents involved the health, welfare, or safety of residents were reported, the involved resident(s) should be removed from the environment that threatened the resident ' s health, welfare, or safety. The P&P indicated the charge nurse and/or nursing supervisor should conduct an immediate resident assessment to identify any injuries or extent of injuries, if any, notify the attending physician of incident for necessary interventions. The P&P indicated the charge nurse and/or nursing supervisor shall initiate resident care plan to reflect current conditions and measures taken to prevent recurrence of event, document findings and if the suspected perpetrator was another resident, the resident shall be separated to avoid further contact.

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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** 44294 Based on interview and record review, the facility failed to report to the California Department of Public Health (CDPH) within two hours, the alleged abuse reported on 4/1/2024 and 4/23/2024 for two out of three sampled residents (Resident 1 and Resident 2). This violation delayed the investigation by the CDPH. Findings: a.) A review of Resident 1 ' s Admission record, dated 4/23/2024, indicated Resident 1 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included essential primary hypertension (high blood pressure) type 2 diabetes mellitus (abnormal blood sugar) and muscle weakness. A review of Resident 1 ' s Minimum Data Set ([MDS], a standardized assessment and care screening tool), dated 4/5/24, indicated Resident 1 was cognitively intact (involving the processes of thinking and reasoning) in making decisions of activities of daily living (ADLs) and able to understand. The MDS indicated Resident 1 required set up for eating, oral hygiene, and personal hygiene and required supervision for toileting hygiene, shower and was independent for upper body dressing, lower body dressing. A review of Resident 1 ' s care plan (CP), titled Abuse, dated 4/1/2023, the goal of care plan indicated to keep Resident 1 free from abuse. The CP interventions indicated the facility would report and they would inform representatives throughout the year regarding the facility ' s policies and procedures (P&P) for identifying and reporting any forms of abuse. A review of Resident 1 ' s History and Physical (H&P), dated 1/30/2024 indicated Resident 1 had the capacity to understand and make decisions. b). A review of Resident 2 ' s Admission record, dated 4/23/2024, indicated Resident 2 was originally admitted to the facility on [DATE], with diagnoses including schizophrenia (a disorder that affects a person ' s ability to think, feel, and behave clearly) and hypertensive heart disease (high blood pressure that affects the heart). A review of Resident 2 ' s MDS, dated [DATE], indicated Resident 2 was able to understand and be understood by others. The MDS indicated Resident 2 required supervision for eating, oral hygiene, toileting hygiene, shower, upper body dressing, lower body dressing, and personal hygiene. A review of Resident 2 ' s CP, titled Episodes of striking out from the transferring facility, dated 1/12/2024, the interventions indicated to notify the physician and or responsible party if there was a change in behavior. The CP interventions included to follow up with a psychiatric evaluation, social services evaluation, assist with psychosocial needs and to monitor and record episodes of striking out. The CP indicated staff would provide redirection for Resident 2. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055525	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/26/2024
NAME OF PROVIDER OR SUPPLIER Crenshaw Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 1900 S Longwood Ave Los Angeles, CA 90016	

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	A review of Resident 2 ' s CP, titled Abuse, dated 7/24/2023, the CP goal was to keep Resident 2 free from abuse and interventions indicated facility would report and inform the representative throughout the year regarding the facility ' s policies and procedures (P&P) for identifying and reporting any forms of abuse. A review of Resident 2 ' s History and Physical (H&P), dated 7/21/2023 indicated Resident 2 had the capacity to understand and make decisions. A review of Resident 2 ' s physician ' s order dated 9/13/2023, indicated to monitor episodes of schizophrenia manifested by striking out and tally by hashmarks for Seroquel (medication used to treat certain mental/mood disorders such as schizophrenia) every shift. A review of Resident 2 ' s Medication Administration Record (MAR) indicated on: 1. 3/31/2024 Resident 2 had two episodes of striking during the night shift. 2. 4/1/2024 Resident 2 had two episodes of striking during morning shift and two episodes of striking during the night shift. 3. 4/2/2024 Resident 2 had two episodes of striking during morning shift. A review of LVN 1 ' s progress notes dated 4/1/2024 at 1:52 a.m., indicated LVN 1 responded to a loud, slammed door at Resident 2 ' s room. The progress notes indicated LVN 1 asked Resident 2, what happened. The progress notes indicated Resident 2 stated he slammed the door because the M . F . [Resident 1] kept opening the door. The progress notes indicated Resident 2 shouted at LVN 1 to close the door. During a concurrent observation and interview on 4/23/2024 at 8:17 a.m. with Resident 1, Resident 1 and Resident 2 were observed in the same room (Room B) as roommates. Resident 1 stated Resident 2 hit him on the face on 4/1/2024, and on 4/23/2024 early in the morning. Resident 1 was observed with a red bruise and a swollen right eye lid. Resident 1 stated Resident 2 hit him on the face (pointing to both eyes and bridge of the nose). Resident 1 stated he told the licensed nurse, and Certified Nurse Assistant (CNA) that Resident 2 kept hitting him. Resident 1 stated, Resident 2 used to close the door so no one would see him hitting Resident 1. Resident 1 stated the facility did not offer him a room change and he did not feel safe with sharing a room with Resident 2. During an interview on 4/23/2024 at 8:46 a.m. with Resident 2, Resident 2 stated he did not like Resident 1 because Resident 1 always wanted to open the door and Resident 2 preferred the door closed so he could sleep better, and for privacy. During an interview on 4/23/2024 at 8:46 a.m. with Certified Nurse Assistant (CNA 1), CNA 1 stated Resident 1 was observed with a red bruise and a swollen right eye lid on his eye around 1:30 a.m. that morning. CNA 1 stated he immediately informed LVN 1 and LVN 1 assessed Resident 1. CNA 1 stated Resident 1 had concerns about Resident 2 hitting him in the face (pointing to both eyes and bridge of the nose for about a month and the concerns had been reported to the Director of Nursing (DON) and Administrator (ADM). CNA 1 stated he did not know if anything had been done for Resident 1. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055525	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/26/2024
NAME OF PROVIDER OR SUPPLIER Crenshaw Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 1900 S Longwood Ave Los Angeles, CA 90016	

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	During a telephone interview on 4/23/2024 at 9:12 a.m. with former Housekeeping Supervisor (HKS), the HKS stated, on 4/1/2024, he observed Resident 2 and Resident 1 in their room, and Resident 2 hit Resident 1. The HKS did not remember the part of Resident 1 ' s body Resident 2 hit. The HKS stated a CNA and LVN (unable to recall names) went into the room to check the residents but left both residents to stay in the same room. The HKS stated he did not know the facility ' s protocol regarding resident-to-resident abuse incidents. During a telephone interview on 4/23/2024 at 10:58 a.m. with the facility ' s Secretary, the Secretary stated she translated (Spanish to English) for LVN 1, when LVN 1 was interviewing Resident 1 on 4/1/2024, regarding the alleged abuse incident. The Secretary stated Resident 1 reported that Resident 2 wanted the door to their room (Residents 1 and 2) closed but Resident 1 wanted the door open (date and time unknown). The Secretary stated, on 4/23/2024 at approximately 1:30 a.m., she also translated for LVN 1, regarding a second abuse incident involving Resident 1 and 2. The Secretary stated Resident 1 reported that Resident 2 hit him on his face and rib cage. The Secretary stated LVN 1 notified the ADM and DON of both incidents but did not move the residents to separate rooms. During an interview on 4/23/2024 at 11:15 a.m. with the DON, the DON stated he did not report the allegation of abuse on 4/1/2024 because it was not reported to him. The DON stated he did not report the allegation of abuse on 4/23/2024 within two hours because he had 24 hours to report it if there were no significant injuries. During a telephone interview on 4/23/2024 at 12:07 p.m. with LVN 1, LVN 1 stated she had written progress notes for Resident 2 for the first incident on 4/1/2024 when Resident 2 had hit Resident 1. LVN 1 stated that on 4/23/2024 at 1:30 a.m., CNA 1 had reported to her Resident 1 stated that Resident 2 had hit him on the face. LVN1 stated she called the secretary to translate for her and Resident 1 stated he had been hit on the face and his rib cage. LVN 1 stated she reported the incident around 1:30 a.m. to both the DON and ADM for incident on 4/1/2024 and for incident on 4/23/2024 around 1:50 a.m. During an interview on 4/24/2024 at 12:14 p.m. with the Director of Staff Development (DSD), the DSD stated according to her in-service for abuse and abuse reporting all alleged abuse should be reported withing two hours to keep residents safe and ensure the abuse allegations are properly investigated. The DSD identified abuse as assault or battery, yelling, using profanity and some of the physical indicators were bruises or burns. A review of the facility ' s undated P&P titled Abuse & Mistreatment of Residents, indicated the facility would report all allegations involving abuse by notifying CDPH within two hours of the knowledge of such incident; followed by a letter explaining the circumstances surrounding the incident.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055525	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/26/2024
NAME OF PROVIDER OR SUPPLIER Crenshaw Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 1900 S Longwood Ave Los Angeles, CA 90016	

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44294 Based on record review and interview, the facility failed to investigate a resident-to-resident altercation on 4/1/2024 between two of three sampled residents (Resident 1 and Resident 2). This deficient practice resulted in Resident 2 hitting Resident 1 in the face on 4/23/2024, that resulted in a red bruise and swelling on right eyelid. This also placed Resident 1 at risk for repeated physical abuse by Resident 2, which had the potential for more serious injuries requiring hospitalization , possible coma, or death. Findings: a). A review of Resident 1 ' s Admission record, dated 4/23/2024, indicated Resident 1 was originally admitted to the facility on [DATE] and initial admitted was 4/10/2023 with diagnosis including essential primary hypertension (high blood pressure) type 2 diabetes mellitus (abnormal blood sugar) and muscle weakness. A review of Resident 1 ' s Minimum Data Set ([MDS], a standardized assessment and care screening tool), dated 4/5/24, indicated Resident 1 was cognitively intact (involving the processes of thinking and reasoning) in making decisions of activities of daily living (ADLs) and able to understand. The MDS indicated Resident 1 required set up for eating, oral hygiene, and personal hygiene and required supervision for toileting hygiene, shower and was independent for upper body dressing and lower body dressing. A review of Resident 1 ' s History and Physical (H&P), dated 1/30/2024 indicated Resident 1 had the capacity to understand and make decisions. b). A review of Resident 2 ' s Admission record, dated 4/23/2024, indicated Resident 2 was originally admitted to the facility on [DATE], with diagnosis including schizophrenia (a disorder that affects a person ' s ability to think, feel, and behave clearly) and hypertensive heart disease (high blood pressure that affects the heart). A review of Resident 2 ' s MDS, dated [DATE], indicated Resident 2 had intact cognition and was independent with mobility. The MDS indicated Resident 2 had schizophrenia and was on antipsychotic medication (medication to manage schizophrenia). A review of Resident 2 ' s care plan, titled Episodes of striking out, dated 1/12/2024, indicated staff will monitor and record episodes of striking out behavior.A review of Resident 2 ' s Medication Administration Records (MAR) indicated a total of six (6) episodes of striking out behavior from 3/31/2024 to 4/2/2024. A review of Resident 2 ' s physician ' s order dated 9/13/2023, indicated quetiapine fumarate (medication for mental disorders) 50 milligrams ([mg] unit of measurement) at bedtime for schizophrenia manifested by episodes of striking out. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055525	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Crenshaw Nursing Home	1900 S Longwood Ave Los Angeles, CA 90016

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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 0610

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

A review of the Licensed Vocational Nurse (LVN 1) progress notes dated 4/1/2024 at 1:52 a.m., the progress notes indicated LVN 1 responded to a loud, slammed door at Resident 2 ' s room (Room B). The progress notes indicated LVN 1 asked Resident 2, what happened. The progress notes indicated Resident 2 stated he slammed the door because the M . F . [Resident 1] kept opening the door. The progress notes indicated Resident 2 shouted at LVN 1 to close the door.

During a concurrent observation and interview on 4/23/2023 at 8:17 a.m. with Certified Nurse Assistant (CNA) 1, Resident 1 and Resident 2 were observed in the same room (Room B). CNA 1 confirmed Resident 1 and Resident 2 were still in the same room (Room B).

During a concurrent observation and interview on 4/23/2024 at 8:17 a.m., Resident 1 and Resident 2 were observed staying in the same room (Room B). Resident 1 stated Resident 2 hit him on the face on 4/1/2024, and on 4/23/2024 early morning. Resident 1 was observed with a red bruise and a swollen right eye lid. Resident 1 stated Resident 2 hit him on the face (pointing to both eyes and bridge of the nose). Resident 1 stated he told the licensed nurse, and Certified Nurse Assistants that Resident 2 kept hitting him. Resident 1 stated Resident 2 used to close the door so no one would see him hitting Resident 1. Resident 1 stated the facility did not offer him a room change and he did not feel safe with sharing a room with Resident 2.

During an interview with on 4/23/2024 at 8:46 a.m. with Resident 2, Resident 2 stated he did not like Resident 1 because Resident 1 always wanted to open the door and Resident 2 preferred the door close so he could sleep better, and he also wanted privacy.

During a telephone interview on 4/23/2024 at 9:12 a.m. with former Housekeeping Supervisor (HKS), the HKS stated, on 4/1/2024, he observed Resident 2 and Resident 1 in their room, and Resident 2 hit Resident 1. The HKS did not remember the part of Resident 1 ' s body Resident 2 hit. The HKS stated a CNA and LVN (unable to recall names) went into the room to check the residents but left both residents in the same room. The HKS stated he did not know the facility ' s protocol regarding resident-to-resident abuse incidents.

During a telephone interview on 4/23/2024 at 10:58 a.m. with the facility ' s Secretary, the Secretary stated he translated (Spanish to English) for LVN 1, when LVN 1 was interviewing Resident 1 on 4/1/2024, regarding the alleged abuse incident. The Secretary stated Resident 1 reported that Resident 2 wanted the door to their room (Residents 1 and 2) closed but Resident 1 wanted the door open (date and time unknown). The Secretary stated, on 4/23/2024 at approximately 1:30 a.m., she also translated for LVN 1, regarding a second abuse incident involving Resident 1 and 2. The Secretary stated Resident 1 reported that Resident 2 hit him on his face and rib cage. The Secretary stated LVN 1 notified the Administrator (ADM) and Director of Nurses (DON) of both incidents but did not move the residents to separate rooms.

During an interview on 4/23/2024 at 11:15 a.m. with the DON, the DON stated he did not report the allegation of abuse on 4/1/2024 because it was not reported to him. The DON stated it was important to investigate all alleged abuse allegations to ensure the safety of the residents and to prevent continued abuse.

During a phone interview with LVN 1 on 4/23/2024 at 12:07 p.m., LVN 1 stated Resident 1 reported to her that Resident 2 hit him on 4/1/2024. LVN 1 stated she had written progress notes for Resident 2 for the incident. LVN 1 also stated she had reported it to the ADM and DON around 1:50 a.m.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055525	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/26/2024

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Crenshaw Nursing Home	1900 S Longwood Ave Los Angeles, CA 90016

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/24/2024 at 12:14 p.m. with the Director of Staff Development (DSD), the DSD stated according to her in-service for abuse and abuse reporting all alleged abuse should be reported withing two hours to keep residents safe and ensure the abuse allegations are properly investigated. The DSD identified abuse as assault or battery, yelling, using profanity and some of the physical indicators were bruises or burns. During a review of the facility ' s P&P titled Abuse & Mistreatment of Residents, undated, the P&P indicated the facility would investigate all allegations involving abuse of any type and would be reported by the charge nurse and/or supervisor immediately to the Director of Nursing.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055525	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/26/2024
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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44294 Based on observation, interview, and record review, the facility failed to develop a comprehensive and resident-centered abuse care plan, on two alleged physical abuse incidents on 4/1/2024 and 4/23/2024, for two out of three sampled residents (Resident 1 and Resident 2). This deficient practice resulted in a repeated physical abuse to Resident 1 by Resident 2 on 4/23/2024, that resulted in a red bruise and swelling on right eyelid. This also placed Resident 1 at risk for repeated physical abuse by Resident 2, which had the potential for more serious injuries requiring hospitalization , possible coma, or death. Findings: a). A review of Resident 1 ' s Admission record, dated 4/23/2024, indicated Resident 1 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnosis of essential primary hypertension (high blood pressure) type 2 diabetes mellitus (abnormal blood sugar) and muscle weakness. A review of Resident 1 ' s Minimum Data Set ([MDS], a standardized assessment and care screening tool), dated 1/5/2024, indicated Resident 1 had an intact cognition, required supervision (oversight help) with toileting and showers and was independent with personal hygiene and mobility (resident completes the activity with no assistance). A review of Resident 1 ' s History and Physical (H&P), dated 1/30/2024 indicated Resident 1 had the capacity to understand and make decisions. b). A review of Resident 2 ' s Admission record, dated 4/23/2024, indicated Resident 2 was originally admitted to the facility on [DATE], with diagnosis including schizophrenia (a disorder that affects a person ' s ability to think, feel, and behave clearly) and hypertensive heart disease (high blood pressure that affects the heart). A review of Resident 2 ' s H&P, dated 7/21/2023 indicated Resident 1 had the capacity to understand and make decisions. A review of Resident 2 ' s MDS, dated [DATE], indicated Resident 2 had intact cognition and was independent with mobility. The MDS indicated Resident 2 had schizophrenia and was on an antipsychotic medication (medication to manage schizophrenia). A review of Resident 2 ' s care plan, titled Episodes of striking out, dated 1/12/2024, indicated staff will monitor and record episodes of striking out behavior. A review of Resident 2 ' s physician ' s order dated 9/13/2023, indicated quetiapine fumarate (medication for mental disorders) 50 milligrams ([mg] unit of measurement) at bedtime for schizophrenia manifested by episodes of striking out. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055525	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/26/2024

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Licensed Vocational Nurse (LVN 1) progress notes dated 4/1/2024 at 1:52 a.m., indicated LVN 1 responded to a loud, slammed door at Resident 2 ' s room. The progress notes indicated when LVN 1 asked Resident 2 what happened, Resident 2 stated he slammed the door because the M F kept opening the door (referring to Resident 1). The notes indicated Resident 2 shouted at LVN 1 to close the door. During a concurrent observation and interview on 4/23/2023 at 8:17 a.m. with the Certified Nurse Assistant (CNA 1), CNA 1 stated Resident 1 and Resident 2 stayed in the same room (Room B), because they were roommates. During a concurrent observation and interview on 4/23/2024 at 8:17 a.m., Resident 1 and Resident 2 were in the same room (Room B). Resident 1 stated Resident 2 hit him on the face on 4/1/2024, and on 4/23/2024 early morning. Resident 1 was observed with a red bruise and a swollen right eye lid. Resident 1 stated Resident 2 hit him on the face (pointing to both eyes and bridge of the nose). Resident 1 stated he told the licensed nurse, and CNA that Resident 2 kept hitting him. Resident 1 stated Resident 2 used to close the door so no one would see him hitting Resident 1. During an interview on 4/23/2024 at 8:46 a.m. with Resident 2, Resident 2 stated he did not like Resident 1 leaving the door open. Resident 2 stated he preferred the door closed so he could sleep better, and for privacy. During an interview on 4/23/2024 at 9:08 a.m. with CNA 1, CNA 1 stated Resident 1 was hit on his eye around 1:30 a.m. that morning by Resident 2. CNA 1 stated he immediately informed LVN 1 and LVN 1 went to assess Resident 1 and called the receptionist to translate. CNA 1 stated that Resident 1 had been complaining of being hit by Resident 2 and the concerns had been reported to the Director of Nursing (DON) and Administrator (ADM), but CNA 1 did not know if anything had been done for Resident 1. During a telephone interview on 4/23/2024 at 9:12 a.m. with former Housekeeper Supervisor (HKS), the HKS stated he gone into the room because they were going to do a deep cleaning for the room and that ' s when he noticed the certified nurse assistant was separating Resident 2 from Resident 1 because Resident 2 was hitting Resident 2. HSK stated certified nurse assistants and licensed nurses were in the room and that was the reason he did not report it. The HKS stated he did not know what the procedure was, but the staff did not change rooms for Resident 1 for Resident 2. During a telephone interview on 4/23/2024 at 10:58 a.m. with the facility ' s Secretary, the Secretary stated he translated (Spanish to English) for LVN 1, when LVN 1 was interviewing Resident 1 on 4/1/2024, regarding the alleged abuse incident. The Secretary stated Resident 1 reported that Resident 2 wanted the door to their room (Resident 1 and 2) closed but Resident 1 wanted the door open (date and time unknown). The Secretary stated, on 4/23/2024 at approximately 1:30 a.m., she also translated for LVN 1, regarding a second abuse incident involving Residents 1 and 2. The Secretary stated Resident 1 reported that Resident 2 hit him on his face and rib cage. The Secretary stated LVN 1 notified the ADM and DON of both incidents but did not move the residents to separate rooms. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055525	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Crenshaw Nursing Home	1900 S Longwood Ave Los Angeles, CA 90016

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 4/23/2024 at 11:12 a.m. with the DON, Resident 2 ' s Medication Administration Records (MAR) for March and April 2024, were reviewed. The DON stated the MAR indicated a total of six (6) episodes of striking out behavior from 3/31/2024 to 4/2/2024. The DON stated staff ' s interventions for Resident 2 ' s striking out behavior included monitoring the resident for 72 hours after each incident, de-escalating the situation, distracting the resident, and having one staff monitor the resident closely. The DON stated staff did not intervene on 4/1/2024, when or after Resident 2 hit Resident 1. The DON stated there were no care plans initiated for neither of the allegations and it was important to create a care plan to prevent further incidents, create effective interventions and to keep residents safe. During a phone interview on 4/23/2024 at 12:07 p.m. with LVN 1, LVN 1 stated she had written progress notes for Resident 2 for the first incident at the beginning of the month when Resident 2 had hit Resident 1. LVN 1 stated she had not documented a change of condition (COC) form, interventions, or a 72-hour resident monitoring for incident on 4/1/2024. LVN 1 stated she reported incident to both DON and ADM immediately after being reported to her. LVN 1 stated that CNA 1 had reported to her after 1:00 a.m. on 4/23/2024 that Resident 1 had reported to CNA 1 that Resident 2 had hit him on the face. LVN 1 stated she called the secretary to translate for her and she had indicated that Resident 1 had been hit on the face and his rib cage. LVN 1 stated she did full body assessment, and she did not notice the red bruise on Resident 1 ' s right eye lid. LVN 1 stated she did not document a COC, progress notes, interventions, report it to doctor and family and she did not do a 72-hour resident monitoring for resident because she had gotten distracted, LVN 1 stated it was important for her to do a COC because it was a tool that would help her fully assess the resident and would guide her on the interventions needed to prevent complications, the COC would had helped her with creating interventions and would had led her to call the doctor and the resident ' s representative. LVN 1 stated, the interventions and the 72-hour monitoring were important to implement to keep the Resident 1 safe. LVN 1 stated she reported the incident around 1:30 a.m. to both DON and ADM. LVN 1 stated she should have moved Resident 1 to another room, but the resident was asleep, and she did not move him, and she did not inform Resident 1. LVN 1 stated it was important to move Resident 1 out of the room to keep him safe and free of abuse. A review of the facility ' s undated policy and procedure (P&P) titled, Abuse & Mistreatment of Residents, indicated the facility should have a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs and is developed and implemented for each resident. A review of the facility ' s undated P&P titled, Abuse & Mistreatment of Residents, indicated the charge nurse and/or nursing supervisor shall initiate resident care plan to reflect current conditions and measures taken to prevent recurrence of event, document findings and if the suspected perpetrator was another resident, the resident shall be separated to avoid further contact.