STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055525	A. Building B. Wing	06/24/2024

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45657 Based on observation, interview and record review, the facility failed to provide adequate supervision during the night shift for one of 4 sample residents (Resident 4). Resident 4 was observed, going to the bathroom unsupervised on 6/14/2024 and 6/20/2024, while Certified Nurses Assistance (CNA) 2, was asleep at the nurse's station. This failure had the potential to lead to accidents, falls and injuries for Resident 4. Findings: A review of Resident 4's Admission Record indicated Resident 4 was admitted to the facility on [DATE], with diagnoses including anxiety (causes feelings of worry and nervousness,), Major Depressive Disorder (mental illness that could affect a person's mood and thoughts characterized by a persistent feeling of sadness and loss of interest and can interfere with your daily life), and dementia (loss of memory, language, problem-solving and other thinking abilities). A review of Resident 4's Fall Risk care plan dated 4/13/2022, indicated Resident 4 was at risk for falls/injury related to general weakness, poor body balance control, poor safety awareness/judgement and use of medications. The care plan indicated nursing Interventions included nursing staff would visibly observe the resident frequently. A review of Resident 4's care plan for ADLs (Activities of Daily Living) dated 11/5/2023, indicated Resident 4 had self-care deficits and required up to limited assist with ADLs related to depression, dementia, cognitive deficits, poor balance, poor safety awareness, unsteady gait (manner of walking) and weakness. The care plan indicated nursing interventions included to attend resident needs promptly and assist with ADLs as needed. A review of Resident 4's Minimum Data Set ([MDS] a standardized care assessment and care screening tool), dated 4/19/2024, indicated Resident 4 had severe cognitive (thought process) impairment, was usually able to understand and usually be understood by others. The MDS indicated Resident 4 required supervision or touching assistance (staff provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) for ADL's such as eating, dressing, toilet use and personal hygiene. (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 4's Fall Risk assessment dated [DATE], indicated Resident 4 had intermittent confusion or poor safety awareness/noncompliance and was unable to stand without assistance/unsteady gait/poor sitting or standing balance. During an interview on 6/21/2024 at 6:15 a.m. with CNA 2, CNA 2 stated, it was not acceptable for nurses to sleep during working hours to ensure safety and protection of residents. CNA 2 stated if nurses were sleeping during work hours, residents could be at risk of falling and not receiving care they needed. CNA 2 also stated, nurses should be working and checking on residents during working hours. During a concurrent review of the facility's camera footages on 6/24/2024 at 10:00 a.m., with the Assistant Administrator (AADM), the following were observed: On 6/14/2024 at 1:00 a.m. CNA 2 was sitting at the nurse's station with eyes closed. On 6/14/2024 at 2:50 a.m. until 3:19 a.m., CNA 2 was sitting at the nurse's station with eyes closed. Resident 4 was observed walking out of his room into the bathroom at the hallway. On 6/14/2024 at 4:08 a.m., CNA 2 was sitting at the nurse's station with eyes closed. Resident 4 was observed walking out of his room into the bathroom at the hallway. On 6/15/2024 at 3:00 a.m., CNA 2 was sitting at the nurse's station with eyes closed. No other staff were observed present at the nurse's station, hallways or walking into resident rooms. On 6/20/2024 at 3:00 a.m., CNA 2 was sitting outside of Residents room with eyes closed. On 6/20/2024 at 5:23 a.m., Resident 4 walked to the bathroom at the hallway and CNA 2 did not assist or supervise the resident. On 6/22/2024 at 3:00 a.m. and 5:00 a.m., CNA 2 was sitting at the nurse's station with eyes closed. During an interview on 6/24/2024 at 12:36 p.m. with the Director of Nursing (DON), the DON stated, nurses need to be vigilant of the residents. The DON stated, residents need to be supervised when getting out of bed to prevent fall and to ensure safety. The DON also stated, the residents needed assistance and care and it was unacceptable for nurses to sleep while working at night unless they were on break and the nurse endorsed the care to another nurse. During an interview with the AADM, the AADM stated, in the camera footages, he observed CNA 2 asleep and did not assist Resident 4. AADM stated, staff were not allowed to sleep and should be providing care and ensuring safety for the residents. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of facility's policy and procedure (P&P) titled, Safety and Supervision of Residents dated, 7/2017 indicated, Resident safety, supervision, and assistance to prevent accidents were facility-wide priorities. The P&P indicated, Resident supervision was a core component of the system approach to safety, and the type and frequency of resident's supervision was determined by the individual resident's assessment needs and identified hazards in the environment. The P&P also indicated, safety risk and environment hazard were identified on an ongoing basis through a combination of employee training and employee monitoring.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45657 Based on observation, interview, and record review, the facility failed to provide a sanitary environment for residents by failing to maintain residents room walls, floors, shower rooms, and laundry area clean. These deficient practices had the potential to result in cross contamination (transfer of harmful bacteria from one person, object, or place to another), pest activity and negatively affect resident's wellbeing. Findings: During an observation on 6/21/2024, at 5:05 a.m., in residents' room [ROOM NUMBER], the walls next to bed A and bed B were observed with brown, dry, dirty stains. During an observation on 6/21/2024, at 5:10 a.m., in residents' room [ROOM NUMBER], the floor behind bed A's headboard was observed with dry, old mouse dropping. During an observation on 6/21/2024, at 5:20 a.m., in residents' room [ROOM NUMBER], the wall, close to the bathroom, was observed with brown spots. During an observation on 6/21/2024, at 5:30 a.m., outside the laundry area, dirty plastic bags was observed placed next to a pile of clothes on a table. The surrounding floor were observed dirty with bags of clothes on the floor and under the laundry carts. During an observation on 6/21/2024, at 5:45 a.m., in the shower room (A), dry pieces of papers and hair were observed on the floor and the walls were observed with black spots. During an interview on 6/21/2024 at 8:12 a.m., with Housekeeper (HK) 1, HK1 stated, she cleaned the facility every day, which included sweeping, mopping the restrooms and shower rooms. HK 1 stated, she did not know who was checking the rooms or documenting the completion of deep cleaning. HK 1 stated, deep cleaning of resident rooms included, cleaning the walls and if the walls were dirty, it should be cleaned daily. HK 1 stated, housekeeping was responsible in keeping the clothes and laundry area clean. HK 1 stated, the clothes should not be in bags on the floor and needed to be folded and kept inside the laundry carts. HK 1 also stated, it was important to keep the rooms, walls and shower room cleaned to keep hygienic conditions for residents. During an interview on 6/21/2024 at 9:50 a.m., with HK 2, HK 2 stated, deep cleaning should be completed on one resident's room daily, however, it was not being done. HK 2 stated she did not conduct deep cleaning for any resident rooms on Thursday, 6/20/24. HK 2 stated, the facility must be clean for resident safety. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 6/21/2024 at 10:08 a.m., with Housekeeping Supervisor (HKS), the facility's deep cleaning report binder was reviewed. HSK stated, deep cleaning included changing curtains, disinfecting walls, mattresses, beds and buffing the floor. HKS stated, it was the facility's protocol to conduct deep cleaning for one resident's room daily and each room would usually be deep cleaned every one to two weeks. HKS stated completion of the deep cleaning would be logged and kept in a binder. The binder included Deep Cleaning Reports dated 5/22/2024, 5/23/2024, 5/27/2024, 5/27/2024, 6/13/2024 and 6/18/2024. HSK stated he did not have supporting documentation to indicate deep cleaning was completed in the resident rooms for other dates in 5/2024 and 6/2024. During an interview on 6/24/2024 at 11:30 a.m. with the Infection Control Nurse (IP), IP stated, keeping the walls dirty was not acceptable. IP stated, the walls could contain germs, and may cause infections if residents touched it. IP stated, the facility needed to prevent infection and provide a clean environment for residents. IP also stated the consequences of not living in a clean environment included disease and health status can get worse. During an interview on 6/24/2024 at 12:36 p.m. with the Director of Nursing (DON), the DON stated, deep cleaning should be completed in one room per day. The DON stated, the HK would empty the room, clean completely, turn mattresses cover, lining out, curtain, walls, deep cleaning and sanitization, mop with bleach wipe surfaces. The DON stated, it was very important to keep the resident's environment clean because the facility was the resident's home, and failing to do so could lead to infection control issues. The DON stated, the facility needed to provide residents a homelike environment and if residents lived in a dirty environment, residents would be prone to infection and sickness, as well to prevent infestation of roaches or mice. A review of facility's policy and procedure (P&P) titled, Housekeeping dated, 2/2021, indicated the facility kept clean and orderly conditions and assists in providing a clean, safe, dignified, happy and healthy environment for residents, by clean rooms, hallways, lobbies, restrooms, corridors, and other work areas so that health standards are met. A review of the facility's P&P titled, Cleaning and Disinfecting Resident's Room. dated 4/2023, indicated, Walls, blinds and window curtains in resident areas will be cleaned when these surfaces are visibly, contaminated or soiled. Personnel should remain alert for evidence of rodent activity (droppings) and report such findings to the environmental services director.