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	04/11/2025

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 0622 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one of four sampled residents (Resident 1) who had severe cognitive impairment, was safely discharged when the facility failed to: 1. Ensure an Interdisciplinary Meeting ([IDT] gathering where healthcare professionals from different disciplines collaborate to discuss a patient's care, develop shared understandings, and coordinate treatment plans) for discharge planning was conducted for Resident 1. 2. Ensure Resident 1 ' s discharge location (house) could meet the resident ' s needs. 3. Follow up with Resident 1 after his discharge from the facility to the house, to ensure Resident 1 was safe and comfortably settled. 4. Ensure Resident 1 had a designated individual to safely administered his medications including Risperdal (medication to treat mental health conditions) and gabapentin (medication to treat nerve pain). 5. To contact the Local Contact Agency (a state-designated entity that provides options counseling to individuals in long-term care facilities interested in exploring community-based services and supports) to notify of Resident 1 ' s discharge. 6. Implement its Policies and Procedures (P&P) titled, Transfer or Discharge, Facility-Initiated, which indicated facility-initiated transfers and discharges, must meet specific criteria, and require resident/representative notification, orientation, and documentation. These deficient practices resulted in Resident 1 being discharged to a house in which her needs could not be met, and the resident was placed at risk for falls, injuries, and worsening medical and psychiatric conditions. On 4/7/2025, Resident 1 became unconscious and was transferred to a General Acute Care Hospital (GACH) for evaluation and treatment. (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 0622 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 4/9/2025 at 3:54 p.m., an Immediate Jeopardy ([IJ] a situation in which the facility's noncompliance with one or more requirements of participation had caused, or is likely to cause serious injury, harm, impairment, or death to a resident) was called in the presence of the AssistantAdministrator (AADM) and Director of Nursing (DON) due to the facility ' s failure to ensure Resident 1 who had severe cognitive impairment, was safely discharged . On 4/11/2025 at 3:39 p.m., the facility submitted an acceptable IJ Removal Plan ([IJRP] a plan with interventions to correct the deficient practice). After validating the IJRP ' s implementation onsite, the IJ was removed on 4/11/2025 at 4:01 p.m. in the presence of Administrator (ADM), AADM, DON, Quality Assurance (QA), and Quality Assurance Consultant (QAC) The IJRP included the following immediate actions: 1. On 4/7/2025, the DON contacted staff member at the property (house) regarding Resident I's discharge location and verified the correct address and contact information. 2. The facility DON and Registered Nurse (RN) supervisor provided in-service to all licensed nurses regarding resident assessment prior to discharge to ensure residents with impaired cognition and inability to make decision to ensure that the receiving facility is safe and appropriate to provide the needed care to the resident after being discharged from the facility. 3. The DON provided in-service to licensed nurses regarding medication safety for discharges. The licensed nurse who assists with discharge will provide detailed instructions to include but not limited to: a. Medication administration, including medication name, dosage, frequency and route, quantity of each medication provided to the resident/responsible party, to ensure sufficient quantity of medications will be provided upon discharge. b. Home health (a healthcare provider that provides medical services to patients in their homes) follow-up to ensure medication compliance after being discharged . 4. The DON provided one-to-one in-service to the social service personnel and emphasized the following: a. 24 hours prior to discharge, the social service will verify the receiving facility/home to ensure accurate address, contact information and a valid license as indicated. b. Within 72 hours after discharge, the social service will contact the resident/responsible party/receiving facility/home health to ensure the resident is well settled-in at the new environment after the discharge. 5. On 4/9/2025, the ADM and the DON notified all licensed nurses and the Social Service personnel of the findings outlined in the IJ template dated 4/9/2025 and conducted in-services regarding the Transfer/Discharge policy, which included the following key components: Conduct a Discharge IDT meeting and develop a discharge care plan after admission to the facility, and then quarterly and as needed to assist the resident in discharge planning and to ensure all discharges are appropriate and safe. (continued on next page)

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F 0622 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	6. The DON provided in-service to licensed nurses and social service personnel regarding measures to ensure residents are discharge to a location that can meet the resident's individual needs. The measures include but not limited to: a. Develop and implement discharge care plan for all residents after admission, and then quarterly and as needed. b. Conducting assessments prior to discharge. c. Verifying the receiving facility/home health to ensure accurate information. d. Following up with resident/responsible party/receiving facility after discharge to ensure the discharge location can meet the resident's needs. Findings: During a review of Resident 1 ' s admission Record, the admission Record indicated Resident 1 was admitted to the facility on [DATE], with diagnoses of dementia (progressive decline in cognitive abilities, such as memory, thinking, and problem-solving,) traumatic fracture (a break in a bone caused by a forceful impact or injury, like a fall or car accident), and schizophrenia (chronic mental health condition characterized by disruptions in thought processes, perceptions, emotions, and behavior.) During a review of Resident 1 ' s Care Plan titled Falls/Injury because of behavioral problems, dementia, and impaired cognition dated 5/8/2022, the care plan indicated to provide 1:1 (one-on-one patient care, where a healthcare professional provides constant attention to a single patient) every shift as ordered due to poor safety awareness. During a review of Resident 1 ' s Minimum Data Set ([MDS], a resident assessment tool), dated 1/29/2024, the MDS indicated Resident 1 was sometimes able to understand and be understood by others. The MDS indicated Resident 1 required supervision for eating, and upper body dressing. The MDS indicated Resident 1 required moderate assistance (helper lifts, holds, or supports trunk or limbs, but provides less than half the effort) with oral hygiene, toileting hygiene, showering/bathing, lower body dressing, putting on/taking off footwear and personal hygiene. The MDS indicated Resident 1 required supervision with rolling left to right, sit to lying, lying to sitting on side of bed, chair/bed-to-chair transfer, tub/shower transfer, and walking 10, 50 and 150 feet. The MDS indicated Resident 1 required moderate assistance to sit, stand and for toilet transfer. The MDS indicated Resident 1 required a mechanically altered diet (change in texture of food or liquids e.g. pureed food, thickened liquids.) The MDS indicated Resident 1 was on antipsychotic (medications used to treat mental health conditions characterized by psychosis [mental health condition characterized by a loss of touch with reality], such as schizophrenia and bipolar [mental health condition characterized by extreme mood swings between periods of high energy, elevated mood, and low mood, loss of interest, and fatigue] disorder) medications. During a review of Resident 1 ' s Order Details dated 1/22/2025, the order indicated Risperidone (drug used to treat certain mental disorders, such as schizophrenia and bipolar disease) 3 milligrams ([mg] unit of measurement), give 1 tablet by mouth at bedtime, for schizophrenia. (continued on next page)

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F 0622 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a review of Resident 1 ' s Order Details dated 2/21/2025, the order details indicated Gabapentin (medication for seizures or nerve pain) oral capsule 300 mg by mouth, two times a day for neuropathy (condition where nerves are damaged or malfunctioning), hold for drowsiness. During a review of Resident 1 ' s Multidisciplinary Progress Record dated 2/26/2025, the record indicated Resident 1 remained disorganized, delusional with positive agitation. During a review of Resident 1 ' s Order Details dated 3/14/2025, the order details indicated may discharge Resident 1 to an Assisted Living Facility. During a review of Resident 1 ' s Los Angeles Fire Department (LAFD) Patient Care Report dated 4/7/2025 at 6:29 p.m., the LAFD report indicated Resident 1 was unconscious, and her mental status was deteriorating (to become worse in condition). The LAFD report indicated a private ambulance was called but upon arriving to the house, 911 had been called due to Resident 1 ' s altered level of consciousness. The LAFD report indicated Resident 1 was not alert and oriented and her vital signs were normal. During a review of Resident 1 ' s GACH records titled emergency room (ER) template dated 4/8/2025 at 8:20 a.m., the report indicated, Resident 1 was brought for altered mental status. The report indicated Resident 1 was non-verbal and did not follow commands or open her eyes and move to pain. During a review of Resident 1 ' s GACH records titled Resident Family Medicine History and Physical (H&P) dated 4/8/2025 at 2:39 p.m., the record indicated Resident 1 was stuporous (confused and slow to react) with a Glasgow Coma Scale ([GCS] tool used to assess a patient's level of consciousness after a brain injury or other neurological issue) 10 (score of 10 suggests the person is drowsy, reduced alertness or consciousness, but may still be able to open their eyes and respond to painful stimuli). The H&P indicated Resident 1 was non-verbal and not following commands. Resident 1 was able to open her eyes and move to pain. The H&P indicated Resident 1 ' s laboratory (lab) results indicated the resident had a urinary tract infection ([UTI] bacterial infection that affects any part of the urinary system,). The report indicated Resident 1 was started on empiric (used when the cause of an illness is uncertain) antibiotics (medications that kill or stop the growth of bacteria). During an interview on 4/8/2025 at 8:26 a.m., with Resident 1 ' s Family Member (FM 1), FM 1 stated the facility called him on 3/14/2024 to inform him Resident 1 was being transferred to another facility because Resident 1 no longer needed the services at facility. FM 1 stated the facility gave him the name and address of the new facility (house)but when he attempted to google the address, he could not find it. FM 1 stated he then attempted to find the name of the facility (house) provided to him and he could not find it either. FM 1stated he called the Skilled Nursing Facility ([SNF] long-term care facility that provides specialized nursing care and rehabilitation services to individuals who need medical or nursing care, or rehabilitation services due to injury, disability, or illness), but the facility told him Resident 1 was no longer under their care and they were no longer responsible for the resident. FM 1 stated Resident 1 did not have a cell phone and was unable to use one because the resident had dementia. (continued on next page)

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F 0622 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 4/8/2025 at 8:49 a.m., with the Ombudsman (an advocate for residents of nursing homes, board and care centers, and assisted living facilities), the Ombudsman stated she had received a complaint from FM 1 stating he could not locate Resident 1. The Ombudsman stated FM 1 called the facility, but the facility was not responding. The Ombudsman stated she had not received a discharge notification for Resident 1. During an interview on 4/8/2025 at 10:48 a.m., with Certified Nurse Assistant (CNA 1), CNA 1 stated Resident 1 had a sitter because she was confused and would try to get out of bed without assistance. CNA 1 stated Resident 1 was at high risk for falling which was the reason the facility had to keep a close eye on her. During a concurrent interview and record review on 4/8/2025 at 11:00 a.m., with Licensed Vocational Nurse (LVN 1), Resident 1 ' s Social Services (SS) Note dated 3/14/2025 at 2:41 p.m., was reviewed. LVN 1 stated the note indicated Resident 1 was accepted at an assisted living facility. LVN 1 attempted to look up the address provided in the SS note through a google search but could not find the listed address. LVN 1 stated she did not know the location of the assisted living facility. LVN 1 stated FM 1 called to inquire about the where abouts of Resident 1, but the facility did not have the information. LVN 1 stated there were no IDT notes, or discharge care plans noted in Resident 1 ' s medical record. During a concurrent interview and record review on 4/8/2025 at 12:17 p.m., with the SS, Resident 1 ' s Social Services IDT Resident Discharge Planning dated 10/30/2024 at 9:26 a.m., was reviewed. The SS stated the record indicated Resident 1 was in the facility without a discharge potential (the likelihood to be discharged). The SS stated the record indicated Resident 1 preferred not to return to the community. The SS stated Resident 1 required a dementia unit, and she (the SS) had not conducted an IDT meeting regarding sending Resident 1 to a house, or assisted living facility. The SS stated the facility ' s marketer initiated Resident 1 ' s transfer and the discharge location was not a dementia unit. The SS stated she received an incorrect address from the marketer, which she provided to FM 1 on 3/14/2025. The SS stated the facility ' s process was to conduct an IDT meeting on admission, quarterly, and as needed to identify the needs and goals for a resident and create a care plan with interventions that would assist the staff to achieve each resident ' s goals. The SS stated she did not conduct an IDT meeting for Resident 1 discharge on [DATE]. The SS stated she did not notify the Local Contact Agency (not known), or Ombudsman and she did not follow up to ensure Resident 1 was comfortably settled after discharge. The SS stated it was important to inform the Ombudsman because the Ombudsman was the resident ' s advocate and could follow up on Resident 1 ' s concerns if there were any. The SS stated the facility met Resident 1 ' s needs and she did not know why the resident was discharge to a house, where his needs could not be met. The SS stated Resident 1 or FM 1 and 2 were not involved in selecting the new location because the marketer found it (the house). The SS stated on 3/14/2025, she informed Resident 1, of the transfer but she was not sure Resident 1 understood. The SS stated with transfers or discharges, the facility was supposed to provide discharge documents to the new (receiving) facility, where Resident 1 was discharged , but no one answered her calls, so she did not provide any discharge documents or information about Resident 1 to the discharge location. The SS also stated that she never followed up to ensure Resident 1 was comfortably settled after discharge. (continued on next page)

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F 0622 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 4/8/2025 at 1:33 p.m., with FM 2, FM 2 stated when he visited the house on 4/7/2025 (time unknown), he noticed Resident 1 looked pale (when the skin appears whiter than usual, often due to illness or fear), like she had lost weight, and the resident could not even talk. FM 2 stated he asked the Landlord (owner of the house) to call 911 for Resident 1 to be transferred to a GACH for evaluation and treatment. During an interview on 4/9/2025 at 10:08 a.m., with the Landlord, the Landlord stated it was his home and he was not running an assisted living facility. The Landlord stated he advertised to rent a bedroom on craigslist (free online classified ads platform where individuals can post and browse listings for jobs, housing, items for sale, services, and more) to help him pay his mortgage. The Landlord stated he was contacted by a Marketer (MK) about a resident (Resident 1) at the facility looking for a place to live. The Landlord stated MK told him (the Landlord) that Resident 1was to be discharged and the resident had no medical issues. The Landlord stated he was not in the healthcare profession and only accepted Resident 1 into his home for rent. The Landlord stated FM 2 requested Resident 1 be sent to a GACH because Resident 1 bruises and FM wanted the GACH to document the bruises. Landlord stated even though he did not observe any bruises on Resident 1 ' s body, he agreed to send Resident 1 to GACH for safety. During an interview on 4/9/2025 at 2:18 p.m., with Physical Therapist (PT), PT stated Resident 1 was unsteady and required someone to walk with her at all times, for safety. PT 1 stated that was the reason she had a sitter otherwise she would fall. During an interview on 4/9/2025 at 1:03 p.m. with Registered Nurse (RN), RN 1 stated on 3/14/2025 around 3:10 p.m. he discharged Resident 1 to what he thought was an assisted living facility. RN 1 stated he attempted to call the receiving facility (house) to give a handoff report on the resident, but the facility (house) did not answer the phone, and he did not call back. RN 1 stated Resident 1 ' s verbal report was not provided to the facility. RN 1 stated on 3/14/2025 at 3:10 p.m., he gave the Emergency Medical Technician (EMT) Resident 1 ' s verbal medication administration information and a printout list of the resident ' s medications. RN 1 stated he did not document the medications Resident 1 was discharged with and did not remember how many pills he gave the resident. RN stated Resident 1 was given important medications like Risperdal and Gabapentin. RN 1 stated if Resident 1 did not take her medications it could lead to worsening of symptoms. RN 1 stated there was also a potential for Resident 1 to overdose, and it was important to educate the resident about his medications, administration times, dosages, and side effects. During an interview on 4/9/2025 at 4:05 p.m., with Resident 1 ' s Physician (MD 1), MD 1 stated she did not give an order for Resident 1 to be discharged because Resident 1 was not ready for discharge to a lower level of care. MD 1 stated no staff notified her that Resident 1 was discharged from the facility. MD 1 stated Resident 1 still required care from the facility. MD 1 stated all communications with the facility were done through messages and the orders were signed by her in batches (group of multiple orders). MD 1 stated she did not review it individually and might have signed the discharge order by accident. MD 1 stated Resident 1 still required care from the facility ' s staff and should not have been discharged . (continued on next page)

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F 0622 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a review of the facility ' s Policies and Procedures (P&P) titled Transfer or Discharge, Facility-Initiated, dated October 2022, the P&P indicated facility-initiated discharges, must meet specific criteria, and required resident/representative notification, orientation, and documentation. The P&P indicated the facility should provide the resident and his representative thirty (30)-day advance written notice of an impending discharge from the facility. The P&P indicated the resident, and representative should be notified in writing, the specific reason for the transfer or discharge, including the effective date of the transfer or discharge, the specific location to which the resident is being discharged . The P&P indicated the facility must send a copy of the discharge notice to the Office of the State Long-Term Care Ombudsman at the same time the notice of discharge was provided to the resident and representative. The P&P indicated a post-discharge plan should be developed for each resident prior to her discharge, and must be reviewed with the resident, and/or his or her family, at least twenty-four (24) hours before the resident's discharge from the facility. The P&P indicated the nursing notes should include documentation of appropriate orientation and preparation of the resident prior to the discharge. The P&P indicated if the resident was discharged for any reason, the basis for the discharge, contact information of the practitioner responsible for the care of the resident, resident representative information including contact information, all special instructions or precautions for ongoing care should be communicated to the receiving facility.