

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 08/12/2025
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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. (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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<p>F 0557</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure one out of three sampled residents (Resident 1) was treated with dignity when requesting to be cleaned by the Certified Nursing Assistant (CNA) 1. This deficient practice of not cleaning Resident upon request left Resident 1 to feel frustrated and upset.</p> <p>Findings: a. During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was initially admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses hemiplegia (a condition characterized by loss of muscle strength), hemiparesis (weakness on one side of the body), osteoarthritis (a condition that causes pain, stiffness, and impaired mobility). During a review of Resident 1's History and Physical (H&P), dated 3/26/2025, the H&P indicated Resident 1 had the ability to make decisions for activities of daily living. During a review of Resident 1's Minimum Data Set (MDS- a resident assessment tool), dated 5/9/2025, the MDS indicated Resident 1 required partial/moderate assistance (helper does less than half the effort) by staff for toileting hygiene, showering, and dressing. The MDS indicated Resident 1 was always incontinent (inability to control the flow of urine from the bladder) with urine. During an interview on 8/12/2025 at 8:45 a.m. with Resident 1, Resident 1 stated the Certified Nursing Assistant (CNA) 1 on the night shift (11 p.m. to 7 a.m.) had pushed on his leg, hit him with his pillow, and was telling him he can clean himself with a rude tone (a manner of speaking that is disrespectful, impolite, and often characterized by a harsh aggressive, or dismissive attitude). Resident 1 stated the way she had treated me made him feel bad and if I did not need help; I would not ask for help. b. During a review of Resident 2's admission Record, the admission Record indicated Resident 2 was initially admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses epilepsy (a chronic neurological condition characterized by recurrent, unprovoked seizures caused by abnormal electrical activity in the brain), idiopathic neuropathy (a type of peripheral neuropathy where the cause of nerve damage cannot be identified), and chronic obstructive pulmonary disease (COPD- a chronic lung disease causing difficulty in breathing). During a review of Resident 2's History and Physical (H&P), dated 7/24/2025, the H&P indicated Resident 2 had the capacity to understand and make decisions. During a review of Resident 2's MDS, dated [DATE], the MDS indicated Resident 2 required partial/moderate assistance by staff for toileting hygiene, showering, and dressing. During an interview on 8/12/2025 at 9:00 a.m. with Resident 2 stated CNA 1 did speak to Resident 1 rudely telling him to change himself and that he could wipe himself since he did not want to wait to be changed. During an interview on 8/12/2025 at 9:17 a.m. with Director of Staff Development (DSD), the DSD stated during morning rounds on 7/17/2025 at 6 a.m. Resident 1 had told her CNA 1 had rough handled him while CNA 1 was cleaning him and spoke rudely. The DSD stated CNA 1 role was to provide care upon request from Resident 1 in a respectful manner. The DSD stated when the CNA 1 did not provide proper care when Resident 1 requested it to be changed. The DSD stated CNA 1 behavior caused Resident 1 to not trust her care and to not want her assistance. During an interview on 8/12/2025 at 2:10 p.m. with Director of Nursing (DON), the DON stated CNA 1 was to treat Resident 1 with dignity and assist him with care. The DON stated CNA 1 was to clean Resident 1 and speak to him respectfully. The DON stated not treating Resident 1 with dignity could make him feel belittled (to make someone feel less important, capable, or worthy). During a review of facility's policy and procedure (P&P) titled, Dignity, dated 2/2021, the P&P indicated residents were to be treated with dignity and respect at all times. The P&P indicated staff are to speak respectfully to residents at all times. The P&P indicated demeaning practices and standards of care that compromise dignity was prohibited and to assist the resident promptly to resident's request for toileting assistance. The P&P indicated staff were expected to not challenge or contradict the resident's beliefs or statements.</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>(continued on next page)</p>

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to implement policies and procedures for one out of three sampled residents (Resident 1) that an abuse allegation was reported within two hours to the California Department of public Health (CDPH) and other agencies. This deficient practice of not reporting an abuse allegation within two hours caused a delay in investigating by the CDPH. Findings: a. During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was initially admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses hemiplegia (a condition characterized by loss of muscle strength), hemiparesis (weakness on one side of the body), osteoarthritis (a condition that causes pain, stiffness, and impaired mobility). During a review of Resident 1's History and Physical (H&P), dated 3/26/2025, the H&P indicated Resident 1 had the ability to make decisions for activities of daily living. During a review of Resident 1's Minimum Data Set (MDS- a resident assessment tool), dated 5/9/2025, the MDS indicated Resident 1 required partial/moderate assistance (helper does less than half the effort) by staff for toileting hygiene, showering, and dressing. The MDS indicated Resident 1 was always incontinent (inability to control the flow of urine from the bladder) with urine. b. During a review of Resident 2's admission Record, the admission Record indicated Resident 2 was initially admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses epilepsy (a chronic neurological condition characterized by recurrent, unprovoked seizures caused by abnormal electrical activity in the brain), idiopathic neuropathy (a type of peripheral neuropathy where the cause of nerve damage cannot be identified), and chronic obstructive pulmonary disease (COPD- a chronic lung disease causing difficulty in breathing). During a review of Resident 2's History and Physical (H&P), dated 7/24/2025, the H&P indicated Resident 2 had the capacity to understand and make decisions. During a review of Resident 2's MDS, dated [DATE], the MDS indicated Resident 2 required partial/moderate assistance by staff for toileting hygiene, showering, and dressing. During a record review of facility's termination notice, Notice to Employee as to Change Relationship, dated 7/22/2025, the termination notice indicated Certified Nursing Assistant (CNA) 1 was discharged effective 7/22/2025 due to unprofessional behavior. During an interview on 8/12/2025 at 8:45 a.m. with Resident 1, Resident 1 stated the Certified Nursing Assistant (CNA) 1 on the night shift (11 p.m. to 7 a.m.) had pushed on his leg, hit him with his pillow, and was telling him he can clean himself with a rude tone (a manner of speaking that is disrespectful, impolite, and often characterized by a harsh aggressive, or dismissive attitude). Resident 1 stated he had notified the head nurse (Director of Staff Development) that morning. During an interview on 8/12/2025 at 9:00 a.m. with Resident 2 stated Resident 1 had told Certified Nursing Assistant (CNA) 1 was speaking rudely to Resident 1. Resident 2 stated she was telling Resident 1 to change himself, and that he could wipe himself if he did not want to wait to be changed. During an interview on 8/12/2025 at 9:17 a.m. with Director of Staff Development (DSD), the DSD stated during morning rounds on 7/17/2025 at 6 a.m. Resident 1 had told her CNA 1 had rough handled him while CNA 1 was cleaning him and spoke rudely. The DSD stated that these alleged actions of CNA 1 were considered abuse and needed to be reported within two hours. During an interview on 8/12/2025 at 12:55 p.m. with the Administrator (ADM), the ADM stated the DSD reported CNA 1 was rude and rough handled Resident 1. The ADM stated the DSD was a mandated reporter and had reported to the him about the alleged abuse. The ADM stated Resident 1 was told by CNA 1 to clean up his own sh The ADM stated when there is an allegation of abuse the staff were to report within two hours. The ADM stated CNA 1 had displayed unprofessional conduct she was suspended on 7/16/2025 and later terminated on 7/22/2025. During a review of facility's policy and procedure (P&P) titled, Abuse, Neglect, Exploitation or Misappropriation- Reporting and Investigation, dated 3/2023, the P&P indicated if resident abuse is suspected, the suspicion must be reported immediately. The P&P indicated immediately is within two hours of an allegation involving abuse or within 24 hours of an allegation that does not involve abuse or result in serious bodily injury. The P&P indicated any employee will be placed on leave pending investigation. The P&P indicated if the investigation reveals that the allegation of abuse are founded, the employee is terminated.</p>		