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	04/24/2026

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to:Ensure the Annex medication storage refrigerator temperature was below 40 degrees Fahrenheit.This deficient practice had the potential to result in the loss of potency and expired medication.Findings:During a concurrent observation and interview, on [DATE] at 8:45 a.m., with Licensed Vocational Nurse 3 (LVN 3), the Annex station medication storage refrigerator which contained 7 insulin pens and vials was observed with an internal temperature of 49 degrees Fahrenheit. LVN 3 stated the refrigerator was reading at 49 degrees and was warm. LVN 3 stated the appropriate refrigerator temperature for refrigerated medications should have been below 40 degrees. LVN 3 stated that the risk when the refrigerator is not within the acceptable temperature range is that the medications could lose its potency.During a review of the facility's policy and procedures (P&P), titled Storage of Medications, dated 3/2023, the P&P indicated Drugs and biologicals used in the facility are stored in locked compartments under proper temperature, light and humidity controls.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a written informed consent (voluntary agreement to accept treatment and/or procedures after receiving education regarding the risks, benefits, and alternatives offered) was obtained and an interdisciplinary team ([IDT] - team members from different disciplines who come together to discuss resident care) meeting was conducted before the initiation of a psychotropic drug (any drug that affects brain activities associated with mental process and behavior) for one of one sampled resident (Resident 26) who had diagnosis of dementia (a progressive state of decline in mental abilities).This deficient practice placed Resident 26 at risk for sustaining adverse effects (undesired effect of a drug) from psychotropic medication.Findings:During a review of Resident 26's Face Sheet (front page of the chart that contains a summary of basic information about the resident), the Face Sheet indicated, Resident 26 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 26's diagnoses included dementia, mood disorder (a mental health condition that primarily affects a person's persistent emotional state, causing intense, long-lasting highs or lows that interferes with daily life), and major depressive disorder (a mood disorder that causes a persistent felling of sadness and loss of interest).During a review of Resident 26's History and Physical (H&P), dated 1/11/2026, the H&P indicated, Resident 26 did not have the capacity to understand and make decisions.During a review of Resident 26's Minimum Data Set ([MDS] - a federally mandated resident assessment tool), dated 2/9/2026, the MDS indicated, Resident 26's cognitive (ability to think and reason) skills for daily decision making were severely impaired (never/rarely made decisions). The MDS indicated Resident 26 required setup assistance (helper assists only prior to or following the activity) from staff with oral hygiene, lower body dressing, and personal hygiene.During a review of Resident 26's Order Summary Report (a document containing active orders), dated 4/23/2026, the Order Summary Report indicated, the physician placed a telephone order on 1/11/2026 for Resident 26 to start on Depakote (drug used to treat mood disorder) 250 milligrams ([mg] - metric unit of measurement, used for medication dosage and/or amount) by mouth twice a day (9:00 a.m. and 5:00 p.m.) for mood swings manifested by uncontrollable extreme mood swings causing outburst of anger. The Order Summary Report indicated, the physician placed a telephone order on 1/11/2026 for Resident 26 to start on Trazodone (drug used to treat depression) 25mg by mouth at bedtime (9:00 p.m.) for major depressive disorder manifested by withdrawn behavior.During a concurrent interview and record review on 4/23/2026 at 10:05 a.m., with Registered Nurse 2 (RN 2), Resident 26's Informed Consent, dated 1/11/2026, was reviewed. The Informed Consent signed by Resident 26 indicated, Resident 26 was on Depakote 250 mg twice a day and Trazodone 25 mg at bedtime. RN 2 stated Resident 26's informed consent for Depakote and Trazodone was not signed by the IDT. RN 2 stated Resident 26 lacks capacity to give informed consent because Resident 26 has a diagnosis of dementia. RN 2 stated Resident 26 should have been placed under the care of the IDT or the bioethics committee (multidisciplinary group designed to address, analyze, and advise on complex ethical challenges). RN 2 stated the facility needs to have an IDT meeting before the initiation of psychotropic medication so the IDT could decide if the psychotropic medication is necessary to the resident.During an interview on 4/23/2026 at 10:26 a.m., with the Social Service Director (SSD), the SSD stated Resident 26 was not under the care of the IDT. The SSD stated there was no IDT or bioethics committee meeting that were completed before the initiation of Resident 26's psychotropic medications. The SSD stated the facility had an IDT meeting with Resident 26 on 2/9/2026 one month after the initiation of psychotropic medication. The SSD stated informed consent signed by Resident 26 was not valid. The SSD stated psychotropic medications have lots of side-effects (unwanted effects of medication) that would be detrimental to resident's health and safety.During a review of the facility's policy and procedure (P&P) titled, Lack of Capacity when Medical Interventions Requires Informed Consent, (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	undated, the P&P indicated, The facility shall conduct an interdisciplinary team review of the prescribed medical interventions prior to the administration of the medical intervention. The P&P also indicated when the resident lacks capacity for informed consent and a psychoactive medication is ordered by the physician, a bioethics meeting will be held and will include the resident's primary physician, another physician along with the facility interdisciplinary team member.

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the Minimum Data Set ([MDS] - a federally mandated resident assessment tool) for two of 14 sampled residents (Residents 2 and 32) reflected an accurate assessment, by failing to:A. Ensure Resident 2's Gabapentin (a medication used primarily used as anticonvulsant and for treatment of certain types of nerve pain) medication was encoded as anti-convulsant medication in the MDS assessment Section N0415 (High-Risk Drug Classes) K1(Anticonvulsant).B. Ensure Resident 32's dialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed) treatment was encoded in the MDS assessment Section O (Special Treatments, Procedures, and Programs) 0110 (J1 - Dialysis). This deficient practice resulted in incorrect data being transmitted to the Center for Medicare and Medicaid Services (CMS) and had the potential to negatively affect the plan of care and delivery of care and services for Residents 2 and 32.Findings:A. During a review of Resident 2's Face Sheet (front page of the chart that contains a summary of basic information about the resident), the Face Sheet indicated, Resident 2 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 2's diagnoses included End Stage Renal Disease ([ESRD] - irreversible kidney failure), dependence on renal dialysis, and Diabetes Mellitus ([DM] - a disorder characterized by difficulty in blood sugar control and poor wound healing).During a review of Resident 2's History and Physical (H&P), dated 11/20/2025, the H&P indicated, Resident 2 had the mental capacity to understand and make decisions.During a review of Resident 2's Medication Administration Record ([MAR] - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) from 3/1/2026 to 3/10/2026, the MAR indicated, Resident 2 was given Gabapentin 100 milligrams ([mg] - metric unit of measurement, used for medication dosage and/or amount) at bedtime (9:00 p.m.) for nerve pain.During a review of Resident 2's MDS assessment, dated 3/10/2026, the MDS indicated, Resident 2 was independent (decisions consistent and reasonable) in cognitive (ability to think and reason) skills for daily decision making. The MDS indicated, Resident 2 required substantial assistance (helper does more than half the effort) from staff with toileting hygiene and showering.During a concurrent interview and record review on 4/22/2026 at 7:37 a.m., with the Minimum Data Set Nurse (MDSN), Resident 2's MDS assessment, dated 3/10/2026, was reviewed. The MDSN stated Resident 2's MDS was completed inaccurately. The MDSN stated there should be a checked mark on Resident 2's MDS Section N0415 (K1) because Resident 2 was taking Gabapentin which was classified as anticonvulsant medication. The MDSN stated accurate coding of medications in the MDS was important so the facility could provide proper care and treatment to the residents.During an interview on 4/22/2026 at 10:54 a.m., with the MDSN, the MDSN stated the facility has no policy and procedure (P&P) for MDS assessment. The MDSN stated the facility follows the Resident Assessment Instrument ([RAI] - a guide that helps nursing home staff use to assess residents and develop care plans) manual for completing the MDS assessment.During an interview on 4/23/2026 at 10:58 a.m., with the Director of Nursing (DON), the DON stated MDS is a coordination of care with the interdisciplinary team ([IDT] team members from different disciplines who come together to discuss resident care). The DON stated it is important to complete the MDS assessment accurately so the CMS would know the condition of the resident.During a review of Centers for Medicare and Medicaid Services Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, version 1.20.1, dated 10/2025, page N-6, indicated to code all high-risk drug class medications in item N0415 according to their pharmacological classification, not how they are being used.B. During a review of Resident 32's Face Sheet, the Face Sheet indicated, Resident 32 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 32's diagnoses included ESRD, dependence on renal dialysis, and hypertension ([HTN] - high blood pressure).During a review of Resident 32's physician order, dated (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	11/22/2024, the physician orders indicated, Resident 32 has an order for dialysis treatment every Monday, Wednesday, and Friday.During a review of Resident 32's MDS, dated [DATE], the MDS indicated, Resident 32 was independent in cognitive skills for daily decision making. The MDS indicated, Resident 32 was independent (resident completes the activity with no assistance from a helper) with oral hygiene, toileting hygiene, and personal hygiene.During a review of Resident 32's H&P, dated 2/14/2026, the H&P indicated, Resident 32 had the capacity to understand and make medical decisions.During a concurrent interview and record review on 4/22/2026 at 7:25 a.m., with the MDSN, Resident 32's MDS assessment, dated 2/4/2026, was reviewed. The MDSN stated Resident 32's MDS was completed inaccurately. The MDSN stated there should be a checked mark on Resident 32's MDS Section O 0110 (J1) because Resident 32 had a dialysis treatment and did not refuse or missed dialysis treatment during the 14 days look back period (the specific time frame within which certain resident conditions and events are assessed) before the Assessment Reference Date ([ARD] - observation end date) of 2/4/2026. The MDSN stated accuracy of assessment in the MDS was important so the facility staff could identify the needs of the resident.During an interview on 4/22/2026 at 10:50 a.m., with the MDSN, the MDSN stated the facility has no P&P for MDS assessment. The MDSN stated the facility follows the RAI manual for completing the MDS assessment.During a review of Centers for Medicare and Medicaid Services Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, version 1.20.1, dated 10/2025, page O-7, indicated for Section O 0110 J1 (Dialysis) to code peritoneal or renal dialysis which occurs at the nursing home or at another facility.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a Preadmission Screening and Resident Review (PASARR) Level 1 screening (a federally required preliminary screening for individuals seeking admission to a Medicaid-certified nursing facility) was completed and resubmitted for one of two sampled residents (Resident 7), who had diagnoses of mental illness (abnormal behavior or disturbing feelings, thoughts, or actions that interfere with every day functioning) and was receiving psychotropic medications (any drug that affects brain activities associated with mental process and behavior).This deficient practice had the potential to result in Resident 5 not appropriately evaluated and not provided the necessary specialized services for mental illness.Findings: During a review of Resident 7's Face Sheet (front page of the chart that contains a summary of basic information about the resident), the Face Sheet indicated, Resident 7 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 7's diagnoses included schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior), major depressive disorder (a mood disorder that causes persistent feeling of sadness and loss of interest), and anxiety disorder (excessive, persistent, and uncontrollable fear, worry, or dread that interferes with daily life). During a review of Resident 7's History and Physical (H&P), dated 1/22/2026, the H&P indicated, Resident 7 had the capacity to understand and make decisions. During a review of Resident 7's Minimum Data Set ([MDS] - a resident assessment tool), dated 1/26/2026, the MDS indicated, Resident 7 was independent (decisions consistent and reasonable) in cognitive (ability to think and reason) skills for daily decision making. The MDS indicated, Resident 7 required moderate assistance (helper does less than half the effort) from staff with eating, oral hygiene, and upper body dressing. During a review of Resident 7's Order Summary Report (a document containing active orders), dated 4/23/2026, the Order Summary Report indicated, the physician placed a telephone order on 2/15/2026 for Resident 7 to start on Olanzapine (a drug used to treat mental illness) 10 milligrams ([mg] - metric unit of measurement, used for medication dosage and/or amount) by mouth at bedtime (9:00 p.m.) for schizoaffective disorder manifested by episodes of paranoid (baseless or excessive suspicion of the motives of others) delusion (false beliefs not based on reality). The Order Summary Report indicated, the physician placed a telephone order on 4/2/2026 for Resident 7 to start on Trazodone (a drug used to treat depression) 150mg by mouth at bedtime (9:00 p.m.) for depression manifested by episodes of feeling sad. During a concurrent interview and record review on 4/22/2026 at 2:00 p.m., with the Licensed Vocational Nurse 4 (LVN 4), Resident 7's PASARR Level 1 completed by General Acute Care Hospital (GACH) on 7/29/2025, was reviewed. LVN 4 stated the PASARR Level 1 screening indicated, Resident 7 had no serious mental illness diagnoses and not on prescribed psychotropic medications. LVN 4 stated PASARR Level II (an in-depth, face-to-face or telehealth assessment triggered when a Level I screen suspects a serious mental illness, intellectual disability, or related condition) mental health evaluation was not required. LVN 4 stated the facility should have completed and resubmitted a new PASARR Level 1 under Resident Review (RR - Status Change) because Resident 7 had a new diagnosis of mental illness and was prescribed psychotropic medications. LVN 4 stated it is important to complete and resubmit a new PASARR Level under Resident Review so the facility would know what kind of psychiatric care and treatment to provide for Resident 7. During a review of the facility's policy and procedure (P&P), titled Preadmission Screening and Resident Review, dated 6/2024, the P&P indicated, The facility will submit a new Level 1 PASARR if the MDS does not match the Level 1 Screening from the GACH or any error or discrepancy in the previous PASARR screening.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to:1). Conduct a Level 2 Pre-admission Screening and Record Review (PASRR, a federal requirement to help ensure that individuals are not inappropriately placed in nursing homes for long term care) for one of 8 sampled residents (Resident 5). This deficient practice had the potential to result in a delay of necessary care and mental health services.Findings: During a review of Resident 5's face sheet (front page of the chart that contains a summary of basic information about the resident), the face sheet indicated Resident 5 was originally admitted on [DATE] and readmitted on [DATE] with diagnoses which included bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs), schizoaffective disorder, bipolar type (a mental illness that is characterized by disturbances in thought), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality). During a review of Resident 5's Minimum Data Set (MDS- a resident assessment tool), dated 2/23/2026, the MDS indicated Resident 5's cognitive skills were severely impaired. The MDS indicated Resident 5 required partial assistance by staff members with activities of daily living (ADLs-routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During a record review, on 4/22/2026 at 10:46 a.m., Resident 5's positive Level 1 PASRR screening, dated 4/18/2021, indicate Resident 5 required a Level 2 PASRR screening. There was no Level 2 PASRR screening in Resident 5's medical chart. During a concurrent interview and record review, on 4/22/2026 at11:11 a.m., with Licensed Vocational Nurse 4 (LVN 4), LVN 4 stated she and all other staff were responsible for conducting PASRR screenings. LVN 4 stated Resident 5's Level 1 PASRR indicated a Level 2 PASRR screening was required. LVN 4 stated Resident 5 did not have a Level 2 PASRR screening performed. LVN 4 stated the facility should had followed up for Resident 5's Level 2 PASRR and did not. LVN 4 stated the risk of not resubmitting PASRR for a resident could result in not being able to provide the mental services that a resident needs. During a review of the facility's policy and procedures (P&P), titled Pre admission Screening and Resident Review (PASRR), dated 6/2024, the P&P indicated, If the DHCS/DDS (undefined) contractor deems a Level 2 evaluation is necessary, the facility will assist the DHCS contractor with additional information, face-to-face visit for further evaluation as indicated.

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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** Based on interview and record review, the facility failed to:1). Ensure care plan for oxygen use was initiated for two of 8 sampled residents (Resident 22 and Resident 6).This deficient practice had the potential to result in a delay in delivery of care and services.Findings: a. During a review of Resident 22's face sheet (front page of the chart that contains a summary of basic information about the resident), the face sheet indicated Resident 22 was originally admitted on [DATE] and readmitted on [DATE] with diagnoses which included chronic obstructive pulmonary disease (COPD- a chronic lung disease causing difficulty in breathing), acute respiratory failure (a critical condition where the lungs cannot adequately transfer oxygen to the blood), pneumonia (an infection/inflammation in the lungs), and bronchitis (inflammation or swelling of the airway tubes that carry air to the lungs, commonly causing a hacking cough with mucus, chest tightness, and wheezing). During a review of Resident 22's Minimum Data Set (MDS- a resident assessment tool), dated 10/17/2025, the MDS indicated Resident 22's cognitive (thinking) skills were moderately impaired. The MDS indicated Resident 22 required maximal assistance from staff members with Activities of Daily Living (ADLs). During an observation, on 4/21/2026 at 10:37 a.m., Resident 22 was observed receiving oxygen via nasal cannula running at 5 liters per minute. During a review of Resident 22's medical chart, on 4/23/2026 at 9:59 a.m., there was no oxygen care plan to be found. During a concurrent interview and record review, on 4/23/2026 at 10:31a.m., with Registered Nurse 2 (RN 2), RN 2 stated care plans were initiated to focus on a resident and how to care for their needs. RN 2 stated care plans were initiated on admission and during a residents' change of condition. RN 2 stated Resident 22 did not have a care plan for oxygen. RN 2 stated the oxygen care plan should have been initiated. RN 2 stated the risk of not initiating care plans could result in not being able to provide care based on the resident's needs. b. During a review of Resident's 6 sheet, the face sheet indicated Resident 6 was originally admitted on [DATE] and readmitted on [DATE] with diagnoses which included COPD, emphysema (a chronic lung disease where the tiny, stretchy air sacs in the lungs are damaged and destroyed), psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality) and bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs). During a review of Resident 6's MDS, dated [DATE], the MDS indicated Resident 6's cognitive (thinking) skills were severely impaired. The MDS indicated Resident 6 was dependent on staff members with ADLs. During an observation, on 4/21/2026 at 12:07 p.m., Resident 6 was observed receiving oxygen via nasal cannula running at 4 liters per minute. During a record review of Resident 6's medical chart, on 4/23/2026 at 10:01 a.m., there was no oxygen care plan to be found. During a concurrent interview, on 4/23/2026 10:38 a.m., with RN 2, RN 2 stated there was no oxygen care plan for Resident 6. RN 2 stated Resident 6 should have had an oxygen care plan. RN 2 stated the risk of not providing an oxygen care plan could result in not being able to provide care for a resident who receives oxygen therapy. During a review of the facility's policy and procedures (P&P), titled Oxygen Administration, dated 10/2010, the P&P indicated, Review the resident's care plan to assess for any special needs of the resident.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one of one resident's (Resident 11) blood pressure was checked prior to the administration of hydrochlorothiazide (drug used to treat high blood pressure). This deficient practice had the potential to result in severe hypotension (low blood pressure) for Resident 11.Findings: During a review of Resident 11's Face Sheet (front page of the chart that contains a summary of basic information about the resident), the Face Sheet indicated, Resident 11 was admitted to the facility on [DATE]. Resident 11's diagnoses included hypertension ([HTN] - high blood pressure), cerebral infarction (a condition that occurs when the blood flow to the brain is disrupted due to issues with the arteries that supply it) with hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and Diabetes Mellitus ([DM] - a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 11's History and Physical (H&P), dated 3/19/2026, the H&P indicated, Resident 11 can understand and make own medical decisions. During a review of Resident 11's Minimum Data Set ([MDS] - a resident assessment tool), dated 3/25/2026, the MDS indicated, Resident 11 was independent (decisions consistent and reasonable) in cognitive (ability to think and reason) skills for daily decision making. Resident 11 required moderate assistance (helper does less than half the effort) from staff with oral hygiene, toileting hygiene, and upper body dressing. During a review of Resident 11's Order Summary Report (a document containing active orders), dated 4/23/2026, the Order Summary Report indicated on 3/19/2026, a physician's telephone order for Resident 11 to start hydrochlorothiazide 12.5 milligrams ([mg] - metric unit of measurement, used for medication dosage and/or amount) 1 tablet by mouth, daily (9 a.m.) for HTN. To hold if systolic blood pressure ([SBP] - top number in a blood pressure reading) less than 110. During an observation on 4/22/2026 at 8:09 a.m., with Licensed Vocational Nurse 1 (LVN 1) in Resident 11's room, LVN 1 was about to administer Resident 11's hydrochlorothiazide 12.5 1 tablet without checking Resident 11's blood pressure. During an interview on 4/22/2026 at 8:11 a.m., with LVN 1, LVN 1 stated it was important to follow the physician's order to check Resident 11's blood pressure before administering the hydrochlorothiazide since it has a medication parameter (a measurable, specific instruction or characteristic used to manage drug therapy). LVN 1 stated giving Resident 11's hydrochlorothiazide medication without first checking the blood pressure would cause hypotension, dizziness and fatigability that would endanger Resident 11's health and safety. During a review of the facility's policy and procedure (P&P) titled, Administering Medications, dated 4/2019, the P&P indicated, Medications are administered in a safe and timely manner. The P&P also indicated medications are administered in accordance with prescriber orders.

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	04/24/2026

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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the recommendation from the Consultant Pharmacist (a professional responsible for reviewing each resident's medication profile monthly to identify and report changes) for one of five sampled residents (Resident 26), was acted upon. This failure had the potential to result in Resident 26 experiencing a delay in treatment. Findings: During a review of Resident 26's Face Sheet (front page of the chart that contains a summary of basic information about the resident), the Face Sheet indicated, Resident 26 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 26's diagnoses included dementia (a progressive state of decline in mental abilities), mood disorder (a mental health condition that primarily affects a person's persistent emotional state, causing intense, long-lasting highs or lows that interferes with daily life), and major depressive disorder (a mood disorder that causes a persistent felling of sadness and loss of interest). During a review of Resident 26's History and Physical (H&P), dated 1/11/2026, the H&P indicated, Resident 26 did not have the capacity to understand and make decisions. During a review of Resident 26's Minimum Data Set ([MDS] - a resident assessment tool), dated 2/9/2026, the MDS indicated, Resident 26's cognitive (ability to think and reason) skills for daily decision making were severely impaired (never/rarely made decisions). The MDS indicated Resident 26 required setup assistance (helper assists only prior to or following the activity) from staff with oral hygiene, lower body dressing, and personal hygiene. During a review of Resident 26's Order Summary Report (a document containing active orders), dated 4/23/2026, the Order Summary Report indicated, on 1/11/2026, a telephone order was placed by the physician for Resident 26 to start Depakote (drug used to treat mood disorder) 250 milligrams ([mg] - metric unit of measurement, used for medication dosage and/or amount) by mouth twice a day (9:00 a.m. and 5:00 p.m.) for mood swings manifested by uncontrollable extreme mood swings causing outburst of anger. During a concurrent interview and record review on 4/23/2026 at 9:25 a.m., with Registered Nurse 2 (RN 2), Resident 26's Consultant Pharmacist Medication Regimen Review ([MRR] - a structured, comprehensive evaluation of a resident's entire medication list, conducted by a pharmacist to ensure safety and effectiveness), dated 2/10/2026, was reviewed. The MRR indicated to consider ordering a Depakote level (a blood test that measures the concentration of the medication to ensure it is within the therapeutic range) for routine monitoring because Resident 26 was receiving Depakote for mood disorder. RN 2 stated the timeframe to follow-up the Consultant Pharmacist MRR report to the resident's physician was 5-7 days. RN 2 stated Resident 26's Consultant Pharmacist MRR report was not communicated to the physician and there was no documentation by facility staff on the progress notes that the Consultant Pharmacist MRR for Resident 26 was completed. RN 2 stated it was important to check Depakote level to monitor drug toxicity (the harmful, damaging, or lethal effects caused by an excessive accumulation of medication in the bloodstream) and for medication adjustment. During an interview on 4/23/2026 at 10:55 a.m., with the Director of Nursing (DON), the DON stated Resident 26's physician should have addressed the Consultant Pharmacist MRR report within a week (from 2/10/2026) after the report was completed. The DON stated it was important to check Resident 26's Depakote level to better regulate the medication and to manage resident's mood condition. During a review of the facility's policy and procedure (P&P) titled, Medication Regimen Reviews, dated 5/2019, the P&P indicated, The attending physician documents in the medical record that the irregularity has been reviewed and what action was taken to address it.

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	04/24/2026

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to ensure the dishwasher chlorine test paper strips (used to test commercial dishwasher for proper sanitation level) were not expired.This deficient practice could result in inaccurate readings that would lead to under-sanitized dishes.Findings: During a concurrent observation and interview on 4/22/2026 at 12:25 p.m., in the kitchen dishwashing machine area, the Dietary Aide 2 (DA 2) tested the dishwashing machine sanitation running water after it was sanitized with chlorine test paper strip. The DA 2 stated the chlorine test paper strip bottle indicated an expiration date of 3/2026. The DA 2 stated he did not check the expiration of the chlorine test paper strip prior to testing. During an interview on 4/22/2026 at 12:30 p.m., with the Dietary Service Supervisor (DSS), the DSS stated using an expired chlorine test paper strip would give a false or inaccurate reading that would lead to improperly sanitized water. During a review of the 2022 U.S. Food and Drug Administration Food Code titled Equipment Code#4-501.114, the Food Code indicated Verifying the adequacy of chlorine-based solutions can be accomplished on an on-going basis by confirming that the concentration, temperature, and pH of the sanitizing solutions comply with paragraph 4-501.114 (A) using acceptable test methods and equipment.

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	055525	A. Building B. Wing	04/24/2026

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 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to meet the required room size measurement of 80 square feet of room space per resident in rooms with multiple residents.This deficient practice could potentially result in the residents not being able to move around freely and could potentially affect residents' health and safety.Findings:During a review of the facility's Client Analysis form, on 4/22/2026 at 10:18 a.m., the facility's Client Analysis form indicated:House Station Roomsa. room [ROOM NUMBER] had three resident beds, which measured 216 square feet.b. room [ROOM NUMBER] had two resident beds, which measured 144 square feet.c. room [ROOM NUMBER] had four resident beds, which measured 252 square feet.d. room [ROOM NUMBER] had three resident beds, which measured 198 square feet.e. room [ROOM NUMBER] had three resident beds, which measured 208 square feet.f. room [ROOM NUMBER] had three resident beds, which measured 208 square feet.f. room [ROOM NUMBER] had four resident beds, which measured 260 square feet.g. room [ROOM NUMBER] had one resident bed, which measured at 99 square feet.h. room [ROOM NUMBER] had one resident bed, which measured at 99 square feet.Annex Station Rooma. room [ROOM NUMBER] had three resident beds, which measured at 168 square feet.b. room [ROOM NUMBER] had four resident beds, which measured at 312 square feet. During an interview on 4/24/2026, at 11:34 a.m., with the Assistant Administrator (AA), the AA stated the Administrator submitted a room waiver form on 4/20/2026. The AA stated some of the facility's rooms were smaller than the required square footage of 80 square feet per resident. The AA stated the risk of not meeting the required square footage for each resident could result in residents not being able to move around freely. The AA stated there was no harm caused to the residents in the affected rooms.During observations made to the multiple affected rooms in the House Station Rooms (Rooms 1, 2, 3, 4, 6, 7, 8, 9 and 10) and Annex Station Room (rooms [ROOM NUMBERS]) on 4/21/2026 to 4/24/2026, the room sizes of the above rooms did not adversely affect the residents health and or safety.The Department is recommending a waiver.